Office of Research and Demonstrations

publications catalog

1996

U.S. Department of Health and Human Services
Health Care Financing Administration

The Health Care Financing Administration (HCFA) is responsible for the Medicare program and Federal participation in State-operated Medicaid programs. HCFA's mission is to assure health security for all beneficiaries. This includes ensuring access to affordable and quality health care services; protecting the rights and dignity of beneficiaries; and providing clear and useful information to beneficiaries and providers to assist them in making health care decisions. Medicare and Medicaid payment and program policies have significant and far-reaching effects on beneficiaries, providers, and payers. Understanding these effects and their causes is essential to the planning and implementation of changes to the health care delivery system.

HCFA produces a series of reports that provide information on a range of issues in the health care financing field, including findings from research and demonstration projects and statistics on the Medicare and Medicaid programs. The *Publications Catalog* is published by HCFA's Office of Research and Demonstrations, and provides synopses and ordering information on available publications.

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September 1996

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1994 Influenza Immunizations Paid for by Medicare

This data book is part of HCFA's 1995 Flu Immunization Campaign. It provides a summary of information on influenza immunizations paid for by the Medicare program in 1994. The data reported in this book reflect the second year of claims experience since HCFA began reimbursing providers for influenza vaccine and its administration on May 1, 1993.

Administratively Necessary Days

This *Report to Congress* is mandated by section 9305(e) of OBRA 1986. It is an analysis of the financial impact that Medicare PPS may have on hospitals that have difficulty discharging patients because of limited access to the nursing home market. The specific congressional mandate for this study was to determine whether payments should be made to hospitals for administratively necessary days, separate from the DRG and outlier payments.

Developing a Prospective Payment System for Excluded Hospitals

This *Report to Congress* is mandated by section 603(a)(2)(C)(ii) of Public Law 98-21 of the 1983 Amendments to the Social Security Act. It focuses on a wide range of HCFA research studies conducted during the last 3 years regarding the inclusion of four classes of facilities excluded under PPS. The report reviews the research studies for each hospital class—children's, psychiatric, rehabilitation, and LTC—to determine whether the findings support legislative and regulatory recommendations for inclusion of each class of facilities under PPS. In addition, the report addresses several points about the nearly 2,000 facilities receiving exclusion status that need to be considered in research and policy development efforts.

Guide for HCFA's Rural Health Care Transition Grant Program

This guide is intended to assist rural hospitals in applying for grants and in implementing the types of changes envisioned by Congress when it introduced the transition grant program. The guide was based on reports by 326 hospitals on their grant progress and on the findings of 98 case studies, during which evaluation staff visited or telephoned the hospitals and spoke with the hospital personnel who had implemented and operated the grant projects.

High-Cost Hospice Care

Mandated by section 6016 of OBRA 1989, this 1994 *Report to Congress* studies the high-cost hospice care provided to Medicare beneficiaries under the Medicare program and evaluates the ability of hospice programs participating in the Medicare program to provide such high-cost care to such patients. Based on such study, this *Report* develops methods to compensate such programs for providing such high-cost care.

Impact of the Changes in the End Stage Renal Disease Composite Rate

This *Report to Congress* is mandated by section 9335(b) of Public Law 99-509. It is an analysis of the impact that the reduction in the ESRD reimbursement rate has had on access to care, quality of care, and mortality trends. Although the impetus for the congressional study was the 1986 rate reduction, the report focuses on the 1983 reduction which was substantially higher and for which more data on utilization and patient outcomes could be collected because of the passage of time.

Impact of the Medicaid Drug Rebate Program: Extramural Research Report

This final report evaluates the impact of the drug rebate program established by OBRA 1990. The report summarizes a project undertaken by the Institute for Health Services Research at the University of Minnesota to assess the implementation and net impact of this legislation on access to, utilization of, and expenditures for prescribed drugs for the Medicaid population.

Medicaid and Institutions for Mental Diseases

This *Report to Congress* is an analysis of the IMD exclusion. Mandated by section 6408 of OBRA 1989, this study reviews HCFA's implementation of the policy and discusses related policy issues. Since the beginning of the Medicaid program, medical assistance has been excluded for certain patients in IMDs. The intent and scope of the IMD exclusion have been sources of controversy between the States and the Federal Government.

Medicare Geographic Practice Cost Index

This 1995 *Report to Congress* discusses alternatives for updating components of the GPCI on a regular basis. GPCI is used to adjust MFS payments for area variations in physicians' cost of practice.

Monitoring the Impact of Medicare Physician Payment Reform on Utilization and Access

This 1995 *Report to Congress* is the Secretary's fifth annual report submitted in response to the requirements of OBRA 1989 to monitor and report annually the impact of changes in Medicare physician payment on access to care. OBRA 1989 introduced significant changes in Medicare physician payment policy. The three major components of the law were: (1) the introduction of the MFS, which was implemented beginning January 1, 1992, under a transition period ending in 1996; (2) the establishment of limits on physicians' charges exceeding the fee schedule amount; and (3) the institution of target rates of growth in expenditures for physicians' services. The intent of these changes is to provide more rational and equitable payment for physicians' services under the Medicare program. The report is available both as an executive summary and as a full report (including the summary).

Pharmacy Reimbursement Rates: Their Adequacy and Impact on Medicaid Beneficiaries

This 1994 *Report to Congress* is mandated by Section 4401 (d) (4) of OBRA 1990. The specific mandates for the study were to determine: "(1) the adequacy of current reimbursement rates to pharmacists under each State medical assistance programs (sic) conducted under title XIX of the Social Security Act; and (2) the extent to which reimbursement rates under such programs have and effect on beneficiary access to medications covered and pharmacy services under such programs." This report addresses research questions in these two major areas: adequacy and access.

Research and Demonstrations in Health Care Financing Status Report: Fiscal Year 1994

This *Status Report* provides basic information in a brief format on the more than 300 active intramural and extramural projects conducted by ORD that relate to the Medicare and Medicaid programs. These projects seek alternative ways to finance, organize, and deliver health services, as well as assess the impact of Federal programs on health care costs, providers, and beneficiaries. A synopsis of each project is provided, which includes the name and address of the awardee, contractor, or grantee organization; the Federal project officer having primary responsibility for the project; a brief description; and current status.

Rural Health Care Transition Grant Program

This *Report to Congress* evaluates the program of RHCT Grants to be awarded to rural hospitals with the goal of increasing their long-term financial stability and management capacity. This program, in accordance with OBRA 1987, was mandated in response to the severe financial distress of many rural hospitals.

Rural Secondary Specialty Demonstration Project

This *Report to Congress* is mandated by section 9302(d)(4) of OBRA 1986, in accordance with the Secretary's requirement to enter into a 3-year Rural Secondary Specialty Demonstration Project with Lake Region Hospital and Nursing Home in Fergus Falls, Minnesota. It is an analysis of the effect that a modified system of making payments under Part A of such title to rural secondary specialty centers would have on both total expenditures under such part and the access of Medicare beneficiaries located in rural areas to quality health care.

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HCFA Statistics, 1995

This reference booklet provides significant summary information about national health care expenditures and HCFA programs.

End Stage Renal Disease, 1992

This *Research Report* reflects a wide range of data and analyses regarding the ESRD program. Much of the data emphasize trends and comparisons over time, making the report a standard reference source which illustrates changes in the nature of the Medicare ESRD populations and in the patterns of treatment.

1995 Data Compendium

This *Data Compendium* contains historic, current, and projected data on Medicare enrollment and Medicaid recipients, expenditures, and utilization. Data pertaining to budget, administrative and operating costs, individual income, financing, and health care providers and suppliers are also included. National data not specific to the Medicare and Medicaid programs may be found throughout the publication.

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The *Health Care Financing Review* is a subscription journal published quarterly by HCFA's Office of Research and Demonstrations. The *Review* seeks to contribute to an improved understanding of the Medicare and Medicaid programs and the U.S. health care system by presenting information and analyses on a broad range of health care financing and delivery issues. The *Review* highlights the results of policy-relevant research and provides a forum for a broad range of viewpoints to stimulate discussions among a diverse audience that includes policymakers, planners, administrators, insurers, researchers, and health care providers. An annual subscription to the Review includes four quarterly issues as well as an annual statisticla supplement.

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Research and Demonstrations in Health Care Financing Active Projects: October 1, 1995

This *Active Projects* Report provides basic information in a brief format on the more than 400 intramural and extramural projects conducted by ORD that relate to the Medicare and Medicaid programs. These projects seek alternative ways to finance, organize, and deliver health services, as well as assess the impact of Federal programs on health care costs, providers, and beneficiaries. A synopsis of each project is provided, which includes the name and address of the awardee, contractor, or grantee organization; the Federal project officer having primary responsibility for the project; a brief description; and current status.

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National Listing of Providers Furnishing Kidney Dialysis and Transplant Services: January 1994

This publication provides beneficiaries and health care professionals with a list of Medicare-approved providers who furnish kidney dialysis and transplant services, and aggregated statistics on those providers. This publication is necessary to help recipients obtain the benefits to which they are entitled under the Medicare ESRD program in addition to providing historical statistics on the number of participating providers.

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Medicaid Drug Use Review Demonstration Projects

This *Report to Congress* is mandated by section 1927(g) of the Social Security Act, as added by section 4401(a)(3) of OBRA 1990. It focuses on the progress to date of the drug use review demonstration projects in Iowa and Washington and the independent review by Abt Associates, Inc.

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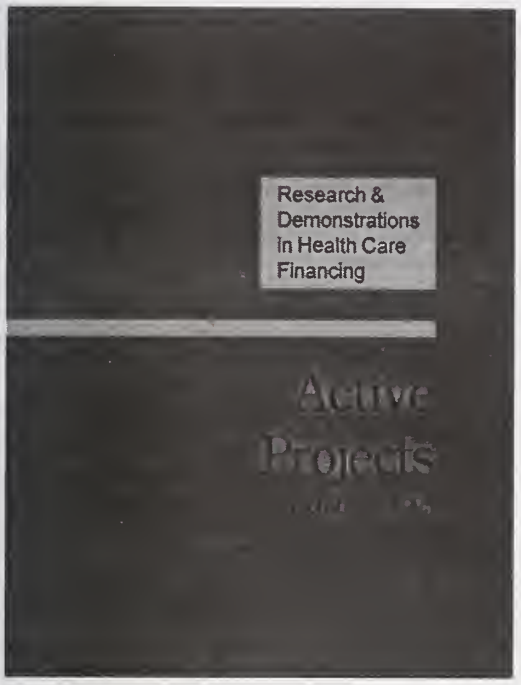

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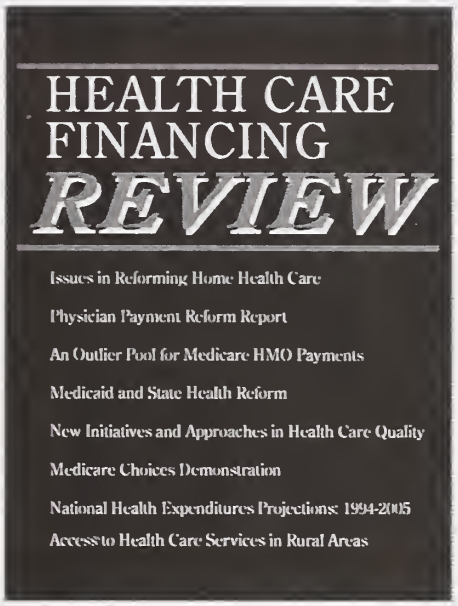

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Analysis of Alternative 'Swap' Proposals and Their Potential Implications for States: Final Report

This report explores swap proposals that are currently being considered in Congress as well as alternatives that have been proposed in the past or which are modifications to those being considered. It reviews the theoretical basis for dividing responsibilities across different levels of Government and synthesizes the available evidence on the likely behavioral responses of States following a reordering of responsibilities. Finally, the report presents an empirical analysis of possible scenarios of the impact of alternative swap proposals across States.

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Assessing the Compatibility of All-Payer Systems and Managed Competition: The Maryland Experience

This study analyzed how HMOs performed under Maryland's all-payer hospital system. The gross difference between HMO hospital costs per discharge and LOS in Maryland was found to be about 25 percent. Less severe admission measured by the DRG values accounted for about 60 percent of the difference. While HMOs had slightly higher per diem costs on average, the average reduction of .66 days per admission accounted for the lower cost per discharge. The study also found that the choice of hospital contributed to HMO cost savings.

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Assessment of Condition-Based Bundling as a Payment Option for Medicare

This report assesses whether HCFA should conduct a demonstration of condition-based bundling. Under this approach, Medicare would pay physician groups a fixed amount for providing a comprehensive bundle of services required to treat physicians with a specified condition. The authors conducted a statistical analysis of Medicare claims data to assess the suitability of six conditions for a bundling demonstration: three acute conditions (hip fracture, acute myocardial infraction, and septicemia) and three chronic conditions (diabetes, heart failure, and glaucoma). They conclude from this analysis that hip fractures deserve additional consideration for a bundling demonstration.

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Assessment and Redesign of Medicare Fee Schedule Areas (Localities): Volume 1—Text

Medicare PPR mandated by OBRA 1989 includes a national fee schedule adjusted by a GPCI unique to each MFS Area (MFSA). Medicare payment localities were established by local insurance carriers at the inception of the Medicare program in 1966 according to local criteria for medical practice and economic conditions. As such, localities have no consistent geographic basis and may reflect historical relationships that are no longer relevant. There had been few changes in payment locality definitions until the implementation of PPR in 1991, when a number of multiple localities became Statewide MFSAs, reducing the number of localities to 240. Recognizing that changes may be needed in MFSA designations, HCFA contracted to reevaluate localities.

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Assessment and Redesign of Medicare Fee Schedule Areas (Localities): Volume 2—Appendix Tables

The appendix tables of this study provide 11 detailed tables of the 4 study options.

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Assessment and Redesign of Medicare Fee Schedule Areas (Localities): Volume 3—Maps

This report provides maps for each of the five fee schedule areas discussed in Volume I. All numerical values on maps are the 1996 MFS Geographic Adjustment Factors.

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Coordinating Health Care Reform With the U.S. Territories: The Case of Puerto Rico

This report provides historical background on the Puerto Rican health care system; demographic and health status trends in Puerto Rico; information on health care system infrastructure; health care financing; and utilization of health care services. The report also describes ongoing health care reform efforts in detail, and discusses key policy issues for health care reform in Puerto Rico.

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Design and Evaluation of a Prospective Payment System for Hospital Based Outpatient Care

APGs are a patient classification and payment system designed to explain the amount and type of resources used in an ambulatory visit. The system is in the public domain and uses 290 groups. Patients within an APG have similar clinical characteristics, similar resource use, and similar cost. The system creates significant procedure and ancillary service groups based on CPT-4 codes and creates medical visit groups using ICD-9-CM diagnosis codes. The APG system describes patients seen across all hospital outpatient settings and payments under the system cover all facility costs. The outpatient visit is the unit of payment for the APG system and includes routine services supplied during the visit.

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Effects of the Florida Medicaid Eligibility Expansion for Pregnant Women, July 1988-June 1989 and CY 1991

Prenatal care and birth outcomes in Florida for deliveries are analyzed and compared for 2 periods, July 1988-June 1989 and CY 1991. The earlier period is just prior to the medicaid income eligibility expansion. CY 1991 began 18 months after the implementation of the expansion. Data sources include: Florida birth and death records, hospital discharge abstracts, medicaid eligibility and claims files, individual encounter records from country health departments, AHA annual survey data for Florida hospitals, and 1990 census data. The amount and timing of prenatal care and birth outcomes for Medicaid and non-Medicaid women are compared in the 2 periods. The authors find evidence that women enrolled in Medicaid as a

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result of the eligibility expansion use more prenatal care and have better birth outcomes than if they had remained uninsured.

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Evaluation of the Medicare SELECT Amendments: Final Evaluation Report

OBRA 1990 authorized an experimental type of supplemental insurance (medigap) policy, termed Medicare SELECT, as a demonstration limited to 15 States for 3 years, effective January 1, 1992. This evaluation of that experiment addresses (1) implementation issues, (2) consumer access, satisfaction and informed consent, (3) premium affordability, and (4) impact on Medicare costs and utilization. The evaluation resulted in mixed findings. In regards to implementation, it was implemented differently in each State, often varying significantly from the implicit legislative expectation, i.e., a network model. Access to services and satisfaction with policies was the same for both medicare SELECT and standard Medigap policy holders. There were no significant health differences between SELECT and non-SELECT beneficiaries.

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Issues Related to the Federal Government Drug Payment Policies in the Reformed Health Care Environment (I)

This report examines the effects of the current Federal drug payment policy (i.e., Medicaid rebate policy) and other related policies (e.g., formularies, prior authorization, drug utilization review) in the rapidly changing health care market environment; it also identifies and analyzes issues to consider in formulating efficient and equitable Federal drug payment policies for the reformed health care environment. To allow for different approaches to the issues, two contracts were funded. The main differences between the two projects are that the first focuses more on conceptual analyses of the industry responses to various policy instruments, while the second focuses more on microeconomic modeling of the industry and theoretical discussions.

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Issues Related to the Federal Government Drug Payment Policies in the Reformed Health Care Environment (II)

This report studies and models various prescription drug payment policies and options currently used or as possible alternatives to be used in the future by the Federal Government in a reformed health care environment. The study examines present and past policies affecting prescription drugs, including reform plans dealing with prescription drug benefits and methods of reimbursement. The authors also summarize the current literature dealing with prescription drug payment policies. They then present a structural model of the prescription drug market to illustrate how various groups of buyers, sellers, and payers interact in this complex market. The authors build an economic model of the rebate mechanism and examine how prices and profits vary across markets depending on rebates and other factors that determine consumer demand and manufacturer supply in the prescription drug market.

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Levels and Determinants of Hospital Inefficiency

Whether hospitals are now less inefficient than they once were is an important public policy question. The study applies two relatively new methods to quantify inefficiency levels in the hospital industry and then compares the results yielded by each method. These new techniques, data envelopment analysis and frontier regression, permit inefficiencies to be conceptualized as deviations from best practice input/output relationships, rather than the average of such relationships. The empirical work estimates levels and temporal changes in inefficiency. These results are then examined in some detail in order to assess the degree to which the two models produce covergent or divergent evidence about hospital efficiency. Multivariate statistical analyses of the main correlates or determinants of measured efficiency are conducted.

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Medicaid Capitated Managed Care Program for SSI Disabled

In 1992, 16 States enrolled members of the SSI-disabled population in capitated and/or FFS managed care plans. Mandatory policies were more common among States, but programs were more prevalent in voluntary States. Capitated programs in mandatory States were smaller, non-profit, privately owned, and had larger numbers of SSI-disabled recipients enrolled than programs in voluntary States. HMOs tended to include more services in their capitation rates than IPAs, but IPAs were more likely to cover supportive services needed by the SSI-disabled population. The majority of administrators know little about this population and had no plans to significantly increase their enrollment. The study shows that States would increase enrollment if they (1) learned more about the demographic characteristics, utilization, and cost experiences of this population, limiting the uncertainty involved with providing services under a risk-based model, and (2) used providers who had experience in serving the SSI-disabled population.

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Medicare Participating Health Bypass Center Demonstration: Final Evaluation Report and Executive Summary (Marketing Activities of Participating Hospitals)

This report is part of the final evaluation of the first 3 years of the Medicare Participating Heart Bypass Center demonstration paying a single global amount to hospitals covering all Part A and B inpatient services. The report presents quantitative and qualitative findings on the marketing activities of hospitals and physicians participating in the demonstration. Analyses of pricing, product promotion, and referral networking are presented separately for each of the seven participating hospitals. The report also presents and analyzes changes in patient volumes, demographics, and market size for each facility. The report concludes with a review and summary of the results of each hospital's own patient satisfaction surveys.

Accession Number: PB96-125570
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Medicare Participating Heart Bypass Center Demonstration: Final Evaluation Report, Volume 1 (The First 3 Years)

This report represents the final evaluation of the first 3 years of the Medicare Participating Heart Bypass demonstration paying a single global amount to hospitals covering all Part A and B inpatient services. It presents results on national trends in Medicare bypass surgery between 1990 and 1993, how demonstration participants were selected, shifts in market shares of demonstration hospitals, net Medicare and beneficiary program savings, hospital cost savings, changes in patient-in-hospital and post-discharge outcomes, lengths of stay, and complications, and changes in appropriateness for surgery including a special study of angiographic interpretations at six sites.

Accession Number: PB96-127626
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Medicare Participating Heart Bypass Center Demonstration: Final Evaluation Report, Volume 2 (Marketing Activities of Participating Hospitals)

HCFA is currently conducting a demonstration to test the feasibility and cost effectiveness of paying hospitals and doctors a single negotiated amount for all hospital and inpatient physician services associated with CABG surgery. HCFA selected seven hospitals to serve as demonstration sites based on the completeness of the package of services each was willing to provide Medicare beneficiaries under the demonstration, the quality of care provided by the hospital and its physicians, and the size of the discount the hospital and doctors were willing to accept for their services. Four sites joined the demonstration in May of 1991.

Accession Number: PB96-127634
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Medicare Participating Heart Bypass Center Demonstration: Appropriateness Study (Model for the Use of CABG and PTCA)

This report addresses the methodological issues in evaluating the appropriateness of bypass surgery under the Medicare Participating Heart Bypass Demonstration. A Technical Advisory Panel of clinicians revised an earlier system

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developed by RAND rating the appropriateness of both CABG surgery and coronary angioplasty. The panel developed a matrix of clinical indications based on a thorough review of the literature, involving the degree of angina, disease anatomy, and surgical risk, then rated each combination of indicators on a one-to-nine basis. Ratings for a few thousand combinations were produced and used to score each Medicare bypass discharge on appropriateness.

Accession Number: PB96-127782
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Medicare Participating Heart Bypass Center Demonstration: Data Collection Design

This report presents the rationale for the evaluation, the data elements required, and the procedures for collecting them. The authors begin by discussing several economic issues of interest to HCFA, including sources of volume increases at the demonstration sites and the relevant savings to the Medicare program (if any), and demonstration administrative costs anticipated at the four hospitals. Next, the authors discuss data collection related to the evaluation of appropriateness of CABG and PTCA. Finally, they discuss assessment of the hospital's marketing activities in order to measure their varying levels of success at promoting the demonstration.

Accession Number: PB96-127790
Price: A04

Medicare Participating Heart Bypass Center Demonstration: Evaluation Design

This report includes the methodologies proposed to analyze demonstration impacts on hospital market shares and volumes, program outlays, hospital costs in treating bypass patients, patient outcomes and appropriateness, and marketing efforts. A special study of the accuracy in measuring degree of stenosis is also described. The evaluation design also describes the plans for conducting in-depth site visits and the role the qualitative information will play in interpreting the quantitative results.

Accession Number: PB96-127808
Price: A04

Outpatient Resource Costing Study: Volume 1 (Final Report) and Volume 2 (Appendices)

This report attempts to determine the reliability of the resource costing methodology for approximately 500 outpatient procedures and visits. The focus is on the resource costs of CPT-4 coded procedures and ICD-9-CM coded medical visits as they are categorized in the APG patient classification system. Data was collected from a geographically dispersed random sample of hospital outpatient departments, ambulatory centers, and physician offices. Only facility costs were collected. The study demonstrates the feasibility of resource costing as a method of identifying the costs for the same procedure across settings. Data that identify the components of direct and indirect costs are presented. Analyses of these costs are included in this report. These also include analysis of procedure combinations and comparisons of resource costs to other relevant measures including charges and to reported costs.

Accession Number: PB96-103908
Price: A99

Part B Physician Sample Redesign

In 1992, HCFA designed a physician sample to replace the BMAD Provider file, which for several years supplied Medicare claims data to support numerous studies of physician payment and other issues. Based on the terminal digits of the UPIN, the new sample is self-weighing and intended to be representative of the physicians treating Medicare beneficiaries. The data base comprises detailed line item information from all available Medicare claims of the sampled physicians. The purpose of this project was to revisit the 1992 design recommendations to develop a more efficient physician sample. A previous evaluation of the sample design had suggested that variability in the physician data was overestimated, leading to sample sizes that could exceed precision requirements. Subsequently, new summary data on 100 percent of physician billings from the NCH yielded State variability estimates and universe counts useful in respecifying the sample.

Accession Number: PB96-112917
Price: A03

See the NTIS Price Schedule on page 83 for current publication prices.
All prices listed are for paper copy unless otherwise indicated.

Per Case Prospective Payment for Episodes of Hospital Care

This report presents two models of bundling physician services for acute inpatient care in Medicare's FFS program. One bundles physician services only; the other bundles all Part A and Part B services provided during a hospital stay. Simulations are conducted using Medicare's 1992 episode data base, which contains all admissions and all related claims during a 5 month period. Models include case-mix adjustment using DRGs, and parameters for outlines, transfers, teaching adjustments disproportionate share, geographic adjustments and windows. An analysis of legal issues is also provided. The policy implications of results are summarized.

Accession Number: PB96-174917
Price: A10

Primer on Hospital and Physician Rate Setting Systems

This primer is a guide for those who want to be informed about the process that would be necessary developing and administering a State-level rate setting system for physician and hospital services. It provides information required to choose among alternatives, design the system, and implement the system.

Accession Number: PB96-162292
Price: A11

Should Medicare Place Physician Groups at Financial Risk? An Assessment of Alternative Demonstration Strategies

This report assesses the feasibility and desirability of conducting a demonstration in which physician groups would be at financial risk for services provided under Medicare and discusses key design issues that would have to be addressed in developing such a demonstration. Based upon a literature review and discussions with key health industry and government representatives, the report suggests that such a demonstration would be feasible given the experience that many physician groups have gained accepting financial risk from HMOs and the high level of interest expressed by some groups provided that they are at risk for some inpatient care. The authors identify major obstacles would have to be overcome for a successful demonstration.

Accession Number: PB96-172804
Price: A06

Unique Physician Identification Number (UPIN) Validation Studies: Final Report

Medicare's Physician Registry was established by HCFA for the purpose of issuing UPINs to the following Medicare providers: doctors of medicine, osteopathy, dental medicine, dental surgery, podiatry, optometry, and chiropractors. To assist in the identification of individual providers, the Registry collects basic professional information. HCFA contracted to perform studies of the Registry's data quality and of several physician enumeration issues. This report presents a report on the UPIN operations of the Registry contractor and the six case-study Medicare Part B Carriers, as well as results of several analyses addressing issues of physician enumeration file and Part B physician claims.

Accession Number: PB96-112891
Price: A05

Utilization and Expenditures for Prescription Drugs in Eight State Medicaid Programs: Final Report, Volumes 1 and 2

Medicaid claims files from 8 States were analyzed to ascertain patterns of use and expenditures for prescription drugs. Use and expenditure patterns were analyzed by medicaid assistance status, basis of eligibility, demographic characteristics, and State policies governing purchasing of drugs. There were two levels of analysis: (1) for each State and (2) multivariate analysis across all States with health care resources at the county level introduced to differentiate by supply factors. The findings were consistent with expectations with respect to age and gender.

Volume 1
Accession Number: PB96-155171
Price: A08

Volume 2
Accession Number: PB96-155189
Price: A21

See the NTIS Price Schedule on page 83 for current publication prices.
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Access to Care in Rural America: The Impact of Hospital Closures

This report examines changes in utilization trends from 1985-89 for catchment areas of 11 rural hospitals that closed inpatient services between 1986-87. The identified closure areas experienced a significant dip in medical admissions in the year of closure. Additionally, Medicare Part B spending growth tended to be slower in closure areas, and out-of-pocket Part B expenses declined in the post-closure period.

Accession Number: PB95-130134
Price: A04

Allocating Practice Costs: Simulations and Other Empirical Work

This report estimates physician practice cost functions and simulates the pricing effects of three different practice cost allocation methods: modifications to the current OBRA 1989 methodology; a PPRC proposal; and Ramsey pricing. Simulations of total programmatic expenditures were done for each of the three methods within five specialties: internists, geriatricians, general practitioners, family practitioners, and general surgeons.

Accession Number: PB95-103784
Price: A07

Analysis of Expansion of Access to Care Through Use of Telemedicine and Mobile Health Services: Report 1 (Literature Review and Analytic Framework)

The broad purpose of this project is to examine available information on the use of telemedicine and mobile health services to expand access to care. In particular, the project will examine issues related to the development of a Medicare coverage policy for such services. The major consideration is whether services provided using telemedicine or mobile health technologies are medically safe and effective. The approach to this project involves literature review, development of a conceptual framework for the analysis of studies examining effectiveness, selected case studies, review of coverage policies of private third-party payers, and examination of utilization review and QA/I models currently in operation as part of existing telemedicine and mobile health systems.

Accession Number: PB95-252813
Price: A09

Analysis of Hospital Medical Staff VPS: Executive Summary

Implementing a VPS for medical staffs requires a number of technical analyses, including a case-mix measure based on inpatient services and payment or performance adjustors at the medical staff level. This report uses the MFS RVUs in claims data to measure physician service V/I. Deflated charges may reflect the historical distortion in the pre-MFS system resulting from physician charging practices. Consequently, the impact of using RVUs instead of charges in the development of the case-mix measure and multivariate analyses of RVUs per admission is examined and compared with prior findings on deflated charges. Data base construction and the development of the case-mix measure are also reviewed.

Accession Number: PB95-170650
Price: A03

Analysis of the Recent Expansions in Medicaid Costs

Using multivariate approaches, this report analyzes the determinants of Medicaid enrollment growth and identified the effects of eligibility expansions on Medicaid expenditures. The study explored the effects of these changes on the equity of the Medicaid program across States. Enrollment growth was found to be significantly affected by eligibility expansions and by the effects of the Zebley Decision and the QMB program. However, eligibility expansions were not the driving force behind expenditure increases. Other Federal policy changes, including the Boren Amendment and nursing home provisions of OBRA 1987, contributed to expenditure growth. The results of the study suggest that dramatic rates of Medicaid expenditure growth should not be expected to continue.

Accession Number: PB95-191722
Price: A07

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Building Analysis Files to Study Medicaid-Financed Deliveries and Birth Outcomes

This report provides a review of methodologies to identify deliveries in claims databases and techniques for linking delivery claims to vital records. This project describes: the data source used, the initial methodology, modifications/ supplements to the initial methodology, a description of approaches used, and recommendations for identifying delivery claims.

Accession Number: PB95-171351
Price: A04

Comparison of the Accuracy of Several Systems for Hospital Quality Screening and Assessment

This report measures the sensitivity, specificity, and predictive values of three different medical-record based screening systems for quality of care problems experienced by patient with coronary artery disease hospitalized for MI, PTCA or CABG surgery. The three screening systems were: (1) an early prototype of the UCDS; (2) Johns Hopkins hospital-wide screens; and (3) Harvard Medical Practice Study screening criteria. For the cardiac patients at Johns Hopkins Hospital, the version of UCDS tested was more sensitive and less specific for detecting quality problems than the other two screening methods, but was much less efficient per quality problem detected. There are differences in sensitivity and specificity depending on whether patients were admitted for MI, angioplasty, or bypass surgery, with UCDS performing significantly better in MI patients than the other two systems.

Accession Number: PB95-231015
Price: A05

Comparison of GPCI Rental Index to Three Sources of Commercial Office Rents

This report compares data from three commercial rent sources with 1992-94 fair market rent (FMR) data used by HCFA in the office rental index of the MFS practice expense GPCI. The primary conclusion is that the FMR cannot be replaced with any of the three commercial rent sources.

Accession Number: PB95-123311
Price: A03

Comparison of Trends in Services Utilization for Hip Fracture Patients: Effects of the Presence of Rehabilitation Units

The report examined whether care in subacute settings is being substituted for that in acute-care settings for patients with hip fractures. Three groups of hospitals were studied during 1984-90: hospitals with and without rehabilitation unit over the entire period and those that instituted a rehabilitation unit in 1987. Key findings: Among all three groups of hospitals, dramatic decline in proportion of Medicare hip fracture patients over 70 years of age discharged to home, while those discharged to SNFs rose; hospitals without rehabilitation units tended to discharge higher proportion to SNFs; similar declines in inpatient length of stay for all 3 groups of hospitals.

Accession Number: PB95-231056
Price: A07

County-Level Population-Weighted Malpractice Indices by Physician Speciality, 1989-92 (for Microcomputers)

This product contains FIPS count identifiers, county names, and 1990 population weights. Population weights provide the general user with measures of relative premiums that are not dependent on the service patterns of the Medicare covered population. The indices compare premiums for a $1 million/$3 million mature claims made policy across counties.

Accession Number: PB95-503454
Price: D02 computer product

Determine Reliability and Adequacy of Coded Diagnoses and Procedures for Services Provided in Physician Office Settings

This report explores methods for quantifying the reliability and adequacy of coded diagnostic and procedure information reported for services provided in physician office settings. Literature reviews, discussions with experts, and interviews with physicians were used as data-gathering tools. A two-phase formal study is recommended to: Establish error rates in Medicare claims submission, determine the extent to which errors are detected, examine the reasons

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for such errors, and identify the potential for developing additional processing mechanisms for more completely disclosing coding errors.

Accession Number: PB95-154761
Price: A05

Development of the Competitive Pricing Proposal for Medicare

This report examines a proposal to replace the current administered-price Medicare payment mechanism with a competitive pricing system. Essential components include: organized annual open enrollment, with required participation by all plans; restrictions preventing plans from selling supplements to those offered by other plans; and government contributions to premiums based on the lowest price for basic coverage submitted within a given area. The competitive pricing system includes FFS Medicare as one option.

Accession Number: PB95-149340
Price: A06

Effect of Market Structure on HMO Financial Performance: Final Report

This report studies the effect of competition on HMO prices and scale and scope economies. Data for the study come from a national sample of HMOs operating over the period 1988 to 1991. The authors find that more competition, measured by the number of HMOs in the market area, reduces HMO premiums. Although this effect does not appear for IPAs before the highest level of competition is reached, it appears throughout the range of competition for group HMOs. At high levels of competition, more market penetration, measured by the percent of the market of the population enrolled in HMOs, reduces premiums for IPAs. High-penetration markets have lower premiums for group HMOs at all levels of competition. HMOs have significant scale economies associated with both non-Medicare and Medicare enrollment.

Accession Number: PB95-221206
Price: A03

Effect of Market Structure on HMO Premiums

This report examines the effects of HMO market structure on HMO premiums from 1988-91. There are two primary findings. First, more competition (i.e., a greater number of HMOs in a given market) reduces HMO premiums. Second, greater market penetration (i.e., greater percentage of market population enrolled in HMOs) reduces IPA premiums. These findings are consistent with the goals of managed care and offer encouragement for managed competition advocates.

Accession Number: PB95-146544
Price: A03

Evaluation of Arizona's Health Care Cost Containment System Demonstration: Fourth Implementation and Operation Report

This report on the ALTCS presents an overview of the program January to December 1993. This program is part of the AHCCCS. This report summarizes the findings in five areas of the ALTCS program: the effectiveness of program contractors; the method of setting capitation payments; the preadmission screening instrument and use of home and community based services; administrative costs; and the PMMIS. The report also summarizes policy implications.

Accession Number: PB95-210266
Price: A19

Evaluation of Arizona's Health Care Cost Containment System Demonstration: Third Implementation and Operation Report

This report on the ALTCS presents an overview of the program for the period October 1991 through December 1992. This program is part of the AHCCCS. This report summarizes the findings in five areas of the ALTCS program: the effectiveness of program contractors; the method of setting capitation payments; the preadmission screening instrument and use of home and community based services; administrative costs; and the PMMIS. The report also summarizes policy implications.

Accession Number: PB95-209219
Price: A15

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Evaluation of Arizona's Health Care Cost Containment System Demonstration: Third Outcome Report

This report is the third outcome analysis of the AHCCCS. The two outcome areas studied in this report are utilization of medical care services under the program, and the quality of care provided. The utilization analysis examines data in the programs' encounter data files as of February 1992 for two long-term care contractors for services received during Years 8 and 9 of the program. It also describes comparative data to be used, definitions of specific data elements for the analysis, and methodological problems in combining Medicare and Medicaid data. The quality of care chapter reports on an analysis of new admissions to the ALTCS and their subsequent outcome with respect to death or transition to another placement.

Accession Number: PB95-209169
Price: A09

Evaluation of the Grant Program for Rural Health Care Transition: Eighth Semi-Annual Progress Report

This document is the eighth semi-annual progress report on the RHCTG Program. It reports on the status of 1990, 1991, and 1992 grantees, based on monitoring reports submitted by the grantees. Several topics are discussed: approaches to physician recruiting adopted by 1991 grantees, effects of management change on progress and finances of 1991 and 1992 grantees, and size, management, staffing, and finances of 1992 grantees at award.

Accession Number: PB95-155438
Price: A04

Evaluation of Medicare SELECT Amendments: Case Study Report

The Medicare SELECT product is an experimental Medicare supplemental insurance policy (medigap) allowed to be sold in 15 States for 3 years. This report is a set of descriptive case studies of each of 13 continuously approved SELECT states and a synthesis of findings across plans. Key case study findings are that (1) SELECT has not increased the number of managed care Medicare supplement products; (2) only about 2.5 percent of Medicare beneficiaries in SELECT states are enrolled; (3) a significant proportion of SELECT networks include only hospitals or hospitals and pharmacies; (4) it appears unlikely that program savings will accrue to Medicare, but beneficiaries who participate may have less expensive premiums than if they purchased identical plans without network restrictions from the same insurers.

Accession Number: PB95-201489
Price: A12

Examining the Medicaid Fiscal Crisis

This report develops and tests empirically a model of State Medicaid enrollment, covered services, expenditures, and payer generosity. The authors tested the hypothesis that taxpayer burden on Medicaid is an increasing function of ability to pay. Results of multiple regression showed that as a State's tax capacity increased, the expenditures on Medicaid were found to increase as well, while substantial disparity in spending at given levels of tax capacity remained across States. Results also showed that inequalities in taxpayer burden were reduced by one-third over the 1981-88 period. A large Medicaid budget share and an above-average tax effort characterized States with a larger Medicaid burden. States with low taxpayer burdens generally had both small Medicaid budgets and below-average tax efforts.

Accession Number: PB95-190971
Price: A15

Exploring the Relationship Between Inpatient Facility and Physician Services

This report examines the relationship between the volume and intensity of Medicare Part A facility services and Part B physician services at the hospital level. Two measures of service are developed using 1991 data—physician RVUs per admission and facility costs per admission. OLS regression suggests that a 10-percent increase in physician services is associated with a 3.4-increase in facility services. Two-stage least squares regression suggests that the impact is larger than that estimated using OLS. Findings suggest that a medical staff policy which promotes cost savings under Part B might also yield savings under Part A.

Accession Number: PB95-169827
Price: A03

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Final Report on Beneficiary Use and Cost of Services for the CAPP CARE Preferred Provider Organization Demonstration

This report analyzes the first year of the CAPP CARE point-of-service non-enrollment model. Factors considered include: number and types of Medicare beneficiaries who used the PPO network, and the degree to which they remained in network; effects of the PPO on service use and expenditures; and the number of specific procedures performed by demonstration physicians relative to other physicians.

Accession Number: PB95-155461
Price: A06

Geographic Variation in Hospital Non-Labor Input Prices and Expenditures

This report studies geographic variation in hospital non-labor input prices to develop an adjustment methodology for Medicare PPS. Sources used include: published secondary data on hospital prices for food, energy, malpractice insurance, and telephone services; the PPS area wage index; and data on case-mix, teaching status, and urbanicity. The study concludes that hospital supply prices are fairly uniform nationally and the lack of a non-labor geographic adjustment in PPS does not create serious inequities.

Accession Number: PB95-126884
Price: A07

Health Care Financing Administration Hospital Service and Productivity Databook: 1963-1991

This data book presents a summary of the changing structure of the hospital industry. It examines rising expenses and revenues, growth in hospital employment and capital inputs, and data on productivity and intensity trends for more than 40 hospital centers. An attachment analyzes costs and productivity trends for hospitals characterized by bed size.

Accession Number: PB95-136685
Price: A06

Healthy Future: The Cost-Utility of Medicare Reimbursement for Preventive Services in an HMO

This report assesses the cost savings and changes in health-related quality of life associated with providing a preventive service package (annual health risk assessment, individual health promotion, and group counseling) for Medicare beneficiaries enrolled in GHC of Puget Sound. Results indicate that the intervention was not cost-effective in improving health status and/or reducing use/costs. The project demonstrated that integration of health promotion into primary care was possible to achieve for older enrollees in GHC with mixed consequences in terms of health behavior change, health status, and use and cost of services.

Accession Number: PB95-173209
Price: A17

Hospital Costs, Financial Status, and Market Structure

This report examines factors associated with Medicare PPS inpatient hospital cost increases from 1983-92. Findings include: rate of incorporation of new technologies into patient care increased; PPS failed to slow increases in ancillary costs and intensity; rate of technology obsolescence in the hospital industry was high; higher cost hospitals provided more intensive care than those with average costs; and hospitals allowed costs to grow more rapidly in response to higher expected revenue growth.

Accession Number: PB95-123535
Price: A11

Impact of the Medicaid Drug Rebate Program on Expenditures, Utilization, and Access

This report assesses the implementation and net impact of the Medicaid drug rebate legislation on access to, utilization of, and expenditures for prescribed drugs for the Medicaid population. The impact of changes in drug restrictions such as formularies and prior authorization programs and changes in manufacturers drug

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prices were analyzed. Aggregate analysis of total Medicaid drug expenditures and rebates is reported by State and in the aggregate State cases studies analyzed the changes in drug expenditures before and after the Medicaid rebate program was implemented.

Accession Number: PB95-221594
Price: A12

Impact of Plan Design on the Value of Coverage: An Analysis of Four Selected Plan Designs

This report examines the range of health insurance plans offered by private-sector employers with 100 workers or more. It addresses several questions related to establishing a standard benefit nationwide. To address these questions, the report compares the value of four health insurance plan designs. Three of the plans were selected to represent low, medium, and high cost designs. The fourth plan is that proposed in the Health Security Act. Among the report's conclusions: The variation in value among existing large-employer plans is modest. Standardizing plan design at or near the current median would affect employers' total costs much less than extending coverage to all workers and their dependents. Universal employer-based coverage would cause substantial differences among industry groups and firm sizes in their costs of covering additional workers due to differences in their workforce demographics.

Accession Number: PB95-199006
Price: A04

Implementing Findings on Volume/Quality

This report provides empirical evidence on the impact of regionalization of hospital services for which there is a strong relationship between higher volume and better outcomes. The first component provides descriptive analysis of the geographic distribution of Medicare cases for selected procedures and services. The study examines the percentile distributions of cases by hospital, and the mean number of cases treated by hospital characteristic. It then looks at the extent to which services are duplicated within metropolitan areas. The second component of the study simulates the effects of regionalizing services. Concentrating cases in fewer centers would increase volumes and avert deaths. This study simulates the effects of regionalization on the number of patients referred to different hospitals, the number of hospitals treating cases, and on the resulting mortality levels.

Accession Number: PB95-173183
Price: A10

Issues Involved in Developing a Standard Benefits Package: Final Report

This report provides a comprehensive review and discussion of the issues involved in designing a standard benefit package for national health care reform. The report covers the following major issue areas: comprehensiveness of package; process for determining covered services; process for modifying coverage; and variation in benefit package offerings. The report includes recommendations on all the issues.

Accession Number: PB95-103933
Price: A09

Medicaid Drug Use Review Demonstration Projects: Report to Congress

This *Report to Congress* covers the implementation and current status of retrospective and prospective drug use review programs in Iowa and Washington. Also discussed are programs to test the effectiveness of on-line prospective drug use review (OPDUR) and reimbursement of pharmacists' cognitive services.

Accession Number: PB95-123303
Price: A03

Marginal Practice Cost of Physician's Services

This report estimates the marginal practice cost for five outputs: Office visits, "other" visits, operations/assists, laboratory tests, and RV-weighted diagnostic tests. The report concludes that 70-80 percent of physician practice expenses are variable costs for both general/family practices and general surgeon practices. This estimate is much higher than the 32 percent PPRC considers in its practice expense allocation methodology. Finally, practice costs appear to vary much less than proportionally with total physician hours worked; therefore,

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estimates provide little empirical basis for allocating indirect expenses in relation to physician work.

Accession Number: PB95-109435
Price: A03

Models for Medicare Payment System Reform Based on Group-Specific Volume Performance Standards

This report presents a payment policy option, GPVPS, which would put physician group practices in the FFS market at risk for all Part A and B services that its Medicare beneficiaries receive. Medicare would share savings incurred to the program with participating provider organizations who beat their targets. It creates incentives for participating provider organizations to manage their beneficiaries' care and the cost of producing/providing those services. As envisioned, this policy is voluntary; physician groups would be required to meet a minimum set of criteria to participate. It is a non-enrollment risk sharing option, beneficiaries' choice of providers is not restricted in any way.

Accession Number: PB95-261129
Price: A08

Options for Federal Funding for State Costs Under Health Care Reform

This report highlights distributional inequities inherent in the current Medicaid program and estimates the magnitude of the redistribution of funds and payment requirements that would result from the implementation of a number of different types of reform. First, the report analyzes the case where the Medicaid program is maintained in its current matching program structure, but the formula is modified to correct inequities in the current formula. Second, the report addresses Medicaid's DSH program. Finally, the report examines the State financing implications of full or partial integration into a broad based national health care reform. The issues discussed in this work are also relevant for any discussion of block grant or swap proposals.

Accession Number: PB95-261137
Price: A07

Per Case Prospective Payment for Episodes of Hospital Care

This report represents one task under a research initiative to evaluate alternative per case prospective payment models for physician inpatient services. This report focuses upon the descriptive analysis of physician inpatient service bundles and two of the design issues, pre- and post-window definitions, and adequacy of DRGs for case-mix measurement.

Accession Number: PB95-226023
Price: A09

Preventive Health Services for Medicare Beneficiaries: Randomized Control Trial of Alternative Methods of Screening and Provision of Preventive Services for Medicare Participants (The Rural Health Promotion Project)

The demonstration provided preventive services to Medicare beneficiaries residing in rural counties in western Pennsylvania. 3,884 demonstration participants received health risk appraisals and were randomly assigned to two treatment groups and one control group. The treatment groups included beneficiaries receiving services at hospital-based and physician offices. The project did not decrease the extent of morbidity in the demonstration population. The project concluded that it is difficult to get people to use preventive services, particularly those services which require a significant amount of time and involvement on the part of the beneficiaries such as nutritional guidance and smoking cessation programs. In addition, it is extremely difficult to identify a capitation rate for preventive services in older adults because utilization rates are low. Furthermore, such programs are most likely to be used by people with more education.

Accession Number: PB95-173571
Price: A19

Reexamination of Medicare's Graduate Medical Education (GME) Payment: Policy Analysis

This report summarizes major policy proposals for changing Medicare's GME payments. It presents six alternative strategies for addressing

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payment policy issues. It additionally explores what HCFA can do to influence training and reimbursement incentives.

Accession Number: PB95-123527
Price: A04

Report to Congress: Medicaid and Institutions for Mental Diseases

This *Report to Congress* reviews HCFA's implementation of the ID exclusion policy. It examines the changes that have occurred in AM services since 1972 and reviews the research literature on the cost effectiveness of AM services. It also describes the relationship of Medicaid to the support of such care and the costs of eliminating the ID exclusion. Finally, it discusses relevant policy issues and presents associated actions and recommendations.

Accession Number: PB95-123287
Price: A07

Senior Health Watch Medicare Preventive Services Demonstration at the Johns Hopkins University

Preventive services were provided to a representative population of Medicare beneficiaries residing in the eastern third of Baltimore City and in small areas of Baltimore County. After a baseline interview covering areas of health status risk and sociodemographics, the population was randomly assigned to either an intervention or control group. Health as measured by the QWB score did not differ significantly at baseline, but there was a significant difference at Year 2 following the intervention. By year 4, there was no difference in health status. The total unadjusted Medicare allowable charges were almost equal in the first year of the intervention, even when payment for the preventive services were included. In the second year, allowable charges were 2.6 percent higher for the control group than the intervention group.

Accession Number: PB95-173134
Price: A10

Specialty Resource-Based Method of Allocating Practice Expense Under the Medicare Fee Schedule

This report proposes and simulates a specialty resource-based method of determining physician practice expense payments under MFS. This method sets practice expense RVUs so that they are the same proportion of total RVUs as practice expenses are of total practice revenues. A specialty resource-based MFS amplifies the MFS redistribution of specialty income by about 50 percent.

Accession Number: PB95-136321
Price: A03

Technical Efficiency of Physician's Practices

This report estimates technical inefficiency in physician practices using the 1988 PPCIS data base. Various forms of inefficiency are defined: technical inefficiency in physician practices, inefficient input mix, scale of operation, and scale of output. Estimates are exploratory and are intended only to define a range of inefficiency.

Accession Number: PB95-128849
Price: A04

Unique Physician Identification Number (UPIN) Validation Studies: Carrier Analysis

This report presents findings from an analysis of Physician Registry data integrity. Several elements were found to be poor in quality: birth year, professional school code, graduation year, and State license number. Also, the following issues were discovered: Logical inconsistencies between pairs of data elements, differences in data elements which should be consistent across physician practice settings, and discrepancies between common data elements. Up to 11,600 providers may have been assigned multiple UPINs.

Accession Number: PB95-138806
Price: A19

Unique Physician Identification Number (UPIN) Validation Studies: Carrier Edits

This report presents findings from an analysis of Physician Registry data integrity. Several elements were found to be poor in quality, and a number of logical inconsistencies were present. This report details a number of algorithms which were developed to assist Medicare contractors in detecting erroneous data and multiple UPIN assignment.

Accession Number: PB95-138780
Price: A07

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Unique Physician Identification Number (UPIN) Validation Studies: Documentation for the UPIN Integrity and Multiple-UPIN Files

This report presents findings from an analysis of Physician Registry data integrity. Several elements were found to be poor in quality, and a number of logical inconsistencies were present. This report describes programs developed to identify data integrity and multiple-UPIN assignment issues. The programs are a valuable tool for assessing Physician Registry data quality. The report is accompanied by a diskette containing the programs.

Accession Number: PB95-137881
Price: A03

Unique Physician Identification Number (UPIN) Validation Studies: Researcher Edits

This report presents findings from an analysis of Physician Registry data integrity. Several elements were found to be poor in quality, and a number of logical inconsistencies were present. This report describes three algorithms: edits to individual variables, edits to detect and resolve logical inconsistencies between pairs of variables, and detection of providers with multiple UPINs. Data integrity specifications, flowcharts, and SAS computer programs are provided to assist researchers in implementing the edits.

Accession Number: PB95-138772
Price: A09

Updating the Geographic Practice Cost Index: Final Report

The GPCI is an input price index used to adjust MFS payments for area variations in physicians' cost of practice. The GPCI has undergone a major benchmark revision using data from the 1990 Census and other data, effective January 1, 1995 and 1996. The purpose of updating is to maintain a GPCI that accurately measures differences in physicians' cost of practice across areas. The optimal frequency of updating depends upon the volatility of the input price measured. This report addresses periodic updates of the GPCI between major benchmark revisions based on the Decennial Census, which can be accomplished only every 10 years. It considers updating each of the four input price indices utilized in the GPCI—(1) professional earning (work GPCI), (2) employee wages (non-physician employee wage index), (3) HUD Fair Market Rents (rental index), and (4) malpractice insurance premiums (malpractice index).

Accession Number: PB95-231825
Price: A03

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All-Payer Ratesetting Systems

This report describes both domestic and international experience with all-payer ratesetting systems and outlines some of the issues associated with implementing such a system in the United States. Additionally, it summarizes the major studies of hospital ratesetting experiments in the United States and provides detailed summaries of the health care systems of Germany, France, Canada, and Japan. It includes a discussion of implementation issues addressed in these systems.

Accession Number: PB94-104049
Price: A05

Analysis of Ambulatory Vision Care Services for Medicare Beneficiaries

This report describes the findings from a study of the vision services provided on an outpatient basis to Medicare beneficiaries by ophthalmologists, optometrists, and other non-vision-care specialists. Considerable variation was found in the delivery of vision care services according to patient demographics, provider specialty, site of care, and the level of health resource supply. Vision care services in the vast majority of cases are delivered by ophthalmologists. Two-thirds of beneficiaries receiving vision care services saw an ophthalmologist exclusively, and 77 percent of beneficiary-level vision care episodes were delivered by ophthalmologists. Non-vision-care specialists deliver a very small proportion of care—less than 3 percent of episodes, exclusive of medical supplies.

Accession Number: PB94-105475
Price: A05

Analysis of Selectivity Bias in the AAPCC

This report tests for the presence of unobserved variables affecting the probability that Medicare beneficiaries choose HMOs over FFS and the costs incurred by FFS beneficiaries. Using a selectivity model and 1988 data from five Medicare-risk HMOs in the Twin Cities, the report finds no statistically significant evidence of biased selection.

Accession Number: PB94-187580
Price: A03

Assessing Medicare Hospital Payment Levels

This study reviews current methods for updating Medicare PPS rates and considers ways of incorporating the performance of efficient hospitals explicitly into the update methodology. Specifically, the project: (1) discusses the role PPS margins play insetting the updates; (2) provides information on the structural and performance characteristics of consistent PPS financial winners and losers; and (3) identifies reference sets of efficient, low-cost hospitals to use as a guide in the setting of future PPS update. This report finds that there are serious flaws in the use of PPS margins to assess hospital performance. While total margins are abetter measure of performance, they suffer serious limitations of their own.

Accession Number: PB94-219201
Price: A05

Assessment of Adequacy of Reimbursement Rates to Pharmacies and Its Impact on the Access to Medication and Pharmacy Services by Medicaid Recipients

OBRA 1990 mandated that a study be conducted that determines the adequacy of reimbursement rates to pharmacists under each State's Medicaid program and the extent to which reimbursement rates under Medicaid have an effect on beneficiary access to medications. This report addresses research questions in two major areas, adequacy and access. The difference between payment and cost measures forms the base for the adequacy measure. The major question regarding adequacy is whether State payments are adequate in relation to the costs of dispensing drugs. The major question regarding access is whether there is a relationship between the adequacy of State payment and access. The report concludes that, in general, payment to pharmacies providing service to Medicaid appears adequate to insure access.

Accession Number: PB94-187689
Price: A06

Beneficiary Use of Services Over Time

This report uses 5 years of data (1985-89) to study growth in beneficiary use of Medicare Part B services. Part B spending per enrollee increased 53.5 percent in 5 years. Real growth in access to services was definitely a factor in

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rising Part B expenditures; user rates grew 10.4 percent over the study period. Service intensity grew 28.3 percent. Changes in per capita incomes, sociodemographic characteristics, and the geographic composition of Medicare enrollees were found to explain over one-third of the total increase in Part B spending over the 5-year period.

Accession Number: PB94-103918
Price: A04

Changes in Classification of Physician Specialty

This report presents an empirical analysis of changes by physicians in Medicare physician specialty designation upon implementation of MFS in 1992. Over 53,000 active physicians had a change in specialty designation in at least one of their practice settings. Summary tables compare specialties of physicians active in 1991 with their specialties in 1993; 1991 BESS charge data are redistributed to the new specialty designations, showing what specialty shares of dollars and services would have been in 1991 if adjusted to MFS specialty designation. A national matrix table shows gross and net flow to new specialties.

Accession Number: PB94-152089
Price: A03

Cost Effectiveness of ESRD Treatment Modalities—Volume 1

This study compares the cost effectiveness of kidney transplantation and five dialysis modalities for a virtual census of 1984-89 Medicare-eligible ESRD patients in selected age groups. Actuarial techniques are used to estimate survival and lifetime Medicare charges. Both intent-to-treat and transplant history models are employed. Charges are discounted and adjusted for inflation and geographic wage differences. Volume 1 includes the text and appendixes.

Accession Number: PB94-160082
Price: A05

Cost Effectiveness of ESRD Treatment Modalities—Volume 2 (Reference Tables and Actuarial Estimates)

The cost effectiveness of kidney transplantation and five dialysis modalities were compared for a virtual census of 1984-89 incident U.S. Medicare-eligible ESRD patients in selected age groups. Actuarial techniques were used to estimate survival and lifetime Medicare charges (LMC) from day 91 or 181 (for elderly and non-elderly patients, respectively) post-ESRD through September 1989, and 24 age/race/disease/modality groups. Both intent-to-treat and transplant history models were employed. LMC were discounted and adjusted for inflation and geographic wage differences.

Accession Number: PB94-160090
Price: A10

Cost Estimates for Expanded Substance Abuse Benefits for Medicaid-Eligible Pregnant Women

This report addresses questions about the extensiveness of substance-exposed births, the types of treatment programs used by substance-abusing pregnant women, the costs of treatment, and the costs of maternal and infant complications from substance abuse. The project develops a spreadsheet to account for both new Medicaid expenditures associated with offering substance abuse treatment services and prenatal care to pregnant women and likely Medicare savings associated with fewer birth complications from substance abuse. The spreadsheet approach allows the expenditure results of five distinct policy interventions to be compared. California, Massachusetts, New York, Texas, South Carolina, and Washington are used as case studies.

Accession Number: PB94-168010
Price: A10

Descriptive Analysis of Medicare Hospital Episodes With Critical Care Billings: Implications for Bundling Services for Pricing

This report analyzes billing and utilization patterns for physician critical care services provided to Medicare beneficiaries and assesses the implications of these findings for bundling these services for pricing. A substantial volume of hospitalizations involving critical care did not report use of the six critical care billing codes. Detailed analyses focus on the hospital episodes with both ICU/CCU use and critical care billing codes, and yield several key findings.

Accession Number: PB94-104429
Price: A05

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Determination of Capitation Payment Rates for Medicare HMO Beneficiaries: Final Report and Executive Summary

This project attempts to improve understanding of the selection efforts arising from voluntary enrollment under Medicare risk contracts; develops methods to adjust for any differences in health risk in determining capitation payment rates for various groups of Medicare HMO beneficiaries; and examines the effects of selection bias on prediction performance of alternative models. The final report also describes and compares risk adjustment models based on different categories of adjustors. All models predicted expenses more accurately than the AAPCC, but more research is needed to determine an optimal model.

Final Report and Executive Summary
Accession Number: PB94-101557
Price: A23

Executive Summary Only
Accession Number: PB94-109774
Price: A03

Developing Rural Health Networks Under the EACH/RPCH Program: Interim Report of the Evaluation of the Essential Access Community Hospital/Rural Primary Care Hospital Program

This report documents the initial development of the EACH program. The report presents information on program development at both the State and local level. State level findings include: States have made uneven progress in program development; program planning and network development is difficult, labor intensive, and time consuming; and the program has been a catalyst for development of broader network concepts. Local level findings include: hospital commitment to the RPCH conversion is currently weak; financial stress is a critical factor, but not the only impetus for RPCH conversion; distinct RPCH models are being developed; networks are shaped by competitive relationships and local circumstances; and physicians play a critical role in facility participation.

Accession Number: PB94-117959
Price: A08

Diagnostic Testing: Policy Analysis of Pricing Options

This study continues previous analyses of fair-return prices for the technical component of diagnostic tests performed in physician office settings. Fair-return prices may need to be adjusted according to volume of testing performed. This study recommends single, volume-independent reimbursement for several diagnostic tests, but volume-related pricing for others.

Accession Number: PB94-154887
Price: A05

Distribution and Concentration of Medicare Hospital Outpatient Department Services

This report explores the distribution, concentration, and utilization of hospital outpatient department services in hospitals of different types in different regions using 1990 claims data for a national 5-percent random sample. Findings include: Over one-half of all services provided to Medicare outpatients are diagnostic testing services. There is a marked contrast between the inpatient and outpatient roles of major teaching and DSHs. There is marked variation across regions in the overall distribution of services provided in hospital outpatient departments.

Accession Number: PB94-103900
Price: A04

Economies of Scale in Physician Practice

Using the HCFA PPCIS for the years 1984-85 and 1988, this report finds increasing returns to scale for single-specialty but not multi-specialty practices. Data show that physicians practicing in midsize groups are 21 percent more productive than solo physicians. Policy options examined include: reducing physician fees by lowering the MFS conversion factor; reducing the practice-expense RVU by the degree of scale inefficiency; calculating MFS practice expenses using solo practices only; and lowering fees for solo practices.

Accession Number: PB94-217130
Price: A07

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Effect of Increased Medicaid Fees on Physician Participation in Tennessee, 1985-88

This study uses a weighted price index and panel estimation techniques to study the impact of increased Medicaid fees on physician Medicaid participation in Tennessee. The overall findings of this study are consistent with earlier studies of physician participation in Medicaid. The nature of the data base resulted in high collinearity among several of the factors used to characterize the county areas. However, panel estimation did lead to stable and meaningful results for the major policy variable. Findings have implications for Medicaid payment policy as well as policies related to physician supply and location.

Accession Number: PB94-150901
Price: A03

Evaluation of the Arizona Health Care Cost Containment System: Second Implementation and Operation Report

This report presents an overview of the ALTCS demonstration for the period July 1990 to September 1991. The ALTCS program is a part of the AHCCCS demonstration. This report summarizes findings concerning six implementation and operation issues: effectiveness of program contractors; method of setting capitation rates; effectiveness of the PAS instrument; use of HCBS; cost of program administration; and information systems. The report also addresses the policy implications of its findings.

Accession Number: PB94-134467
Price: A13

Evaluation of the Arizona Health Care Cost Containment System: Second Outcome Report

This report addresses ALTCS outcome issues through September 1991. This report summarizes findings for three outcome areas: cost (acute and LTC programs); utilization (acute and LTC); and quality of care in ALTCS. The report also addresses the policy implications of its findings.

Accession Number: PB94-134475
Price: A19

Evaluation of Global Budgeting Strategies

This study documents practical experience with full and partial global budgeting in the U.S. and abroad and assesses options for implementing health budget caps in the U.S. The report includes case studies of national systems, a community-wide system, government-administered systems, and managed-care systems.

Accession Number: PB94-203916
Price: A10

Evaluation of the New York State PACs Project: Final Synthesis Report

Under funding from HCFA, the NYS Department of Health designed the Products of Ambulatory Care (PAC) case-mix classification and payment system for ambulatory care. NYS received a waiver to test the PAC system in nine demonstration hospital outpatient clinics and eight freestanding health center clinics. Beginning in 1987, PACs became the basis for reimbursement for Medicaid for the demonstration facilities. This report assesses the implementation and operation of the PAC system for nonsurgical ambulatory care. The report also analyzes the impact on practice patterns and assesses the applicability of the PAC system to the Medicare program.

Accession Number: PB94-112794
Price: A12

Examination of Alternative Methods for Calculating Relative Values for Practice Expense

OBRA 1989 mandated that relative values for practice expenses under MFS be based on charges. This report investigates alternative methodologies. Part 1 develops a method in which indirect costs are paid based on the characteristics of the practice or the types of services performed. Part 2 explores a method to develop Ramsey prices.

Accession Number: PB94-141140
Price: A06

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Final Detailed Report for the Evaluation of the Municipal Health Services Program Demonstrations

The MHSP Demonstration was implemented in 1978 as an effort to improve access to health care in medically underserved urban areas. The objective was to help cities build upon their existing public health resources to develop or strengthen networks of community clinics to provide primary and preventive health care services to the inner-city poor. The program was established in five cities with funding from the RWJF and was supported by Medicare and Medicaid waivers from HCFA. Foundation support ended in 1984, but HCFA has continued to grant the Medicare waivers in four of the cities, under Congressional mandates. The program has thus evolved into a demonstration limited to Medicare beneficiaries. The OBRA 1989 extended the MHSP Medicare waiver through December 1993.

Accession Number: PB94-131612
Price: A10

Final Evaluation Report on the 1989 Grant Program for Rural Health Transition: Send Us More Doctors, Please

This report evaluates the effects of the RHCTG program on hospitals that received grants in 1989 and completed the 3-year grant cycle in 1992. Approximately 925 hospitals received a total of $92 million in Federal funds through FY 1993. Two factors affecting these hospitals were dominant during the evaluation: physician recruitment and retention, and the difficulties of the smallest (under 30 bed) hospitals.

Accession Number: PB94-142312
Price: A11

High-Cost Hospital Medical Staff Proposal in the Health Security Act: Distributional Impacts

One proposal included in the Clinton Administration's Health Security Act would limit payments to physicians in hospitals with high-cost medical staffs. This report simulates the impact of this proposal on medical staffs by hospital type and State. Data from 1991-92 are used.

Accession Number: PB94-203254
Price: A03

Hospital Wages and the Prospective Payment System Wage Index

This report evaluates the accuracy of the area wage index of the Medicare PPS. Seven factors are found to be key wage determinants: area opportunity wages; area hospital-specific wages; hospital size; case mix; occupation mix; unionization; and competitiveness of the area labor market. These factors account for 70 percent of variation in hospital wages.

Accession Number: PB94-207560
Price: A10

Impact of Psychological Intervention on Health Care Utilization and Costs: The Hawaii Project

This report studies whether targeted, focused mental health treatment would reduce net health care costs in Hawaii's Medicaid population. Findings include: Less than 3 percent of the study group received targeted, focused mental health treatment. Mental health services significantly reduced health care costs. Exclusive use of targeted, focused mental health treatment was significantly more cost effective than the exclusive use of other mental health services.

Accession Number: PB94-102100
Price: A25

Implementation of the Medicare Physician Preferred Provider Organization (PPO) Demonstration

This report describes the implementation experience of the five PPOs in the Medicare PPO demonstration. Descriptions of each PPO include: design of the benefit package, including customer incentives; marketing approaches; criteria for provider selection; utilization management procedures; and quality assurance.

Accession Number: PB94-208923
Price: A08

Interim Report on Beneficiary Use and Cost of Services for the CAPP CARE Preferred Provider Organization Demonstration

This report analyzes the first year of the CAPP CARE point-of-service non-enrollment model. Factors considered include: number and types

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of Medicare beneficiaries who used the PPO network, and the degree to which they remained in network; effects of the PPO on service use and expenditures; and the number of specific procedures performed by demonstration physicians relative to other physicians.

Accession Number: PB94-203064
Price: A08

Medicaid Managed Care: The Effects of Fee-for-Service Case Management on Enrollees' Service Use

This report examines the effects of FFS managed care on AFDC recipients. Enrollees in voluntary programs use more services than enrollees in mandatory programs. Enrollees appear to substitute medical office visits for physician visits in clinics and hospital outpatient departments. Managed care appears to significantly increase the likelihood of a hospital discharge for adults but to decrease the likelihood for children. The reduction of hospital use by children almost completely offset the increased cost of greater use of ACS.

Accession Number: PB94-121761
Price: A03

Medicaid Physician Fees, 1990: Results of a New Survey

This report documents the assembly of data from State Medicaid programs on the fees paid to physicians for a set of 56 procedures. The procedures are representative of the market baskets consumed by different types of Medicaid recipients—infants, children, women in child-bearing years, older males and females, and the disabled. Data allowed comparisons among Medicaid, Medicare, and private payers for different population groups and different types of services.

Accession Number: PB94-121779
Price: A04

Medical Staff Risk Pool Policies: Stability and Simulation

This report uses a 100-percent beneficiary file for seven States to analyze policies that place medical staffs at risk for volume and intensity of services provided. The temporal stability of volume per admission is examined at the hospital level. Findings suggest that temporal instability is not an intractable problem.

Accession Number: PB94-203262
Price: A03

Medicare Hospital Outpatient Department Services and the Diffusion of Technology

This report uses 1990 claims data to identify a set of high-technology services provided in hospital outpatient departments and examines the diffusion of these technologies by hospital type and region. There are considerable variations across hospital types in the diffusion of technology. The selected technologies tend to be concentrated in large, urban, and teaching hospitals. In the regional analysis, the New England, Mid-Atlantic, South Atlantic, and East North Central regions show consistently higher levels of technology diffusion than other regions. In a few regions, diffusion of a particular technology markedly exceeds that of other regions.

Accession Number: PB94-103843
Price: A04

Medicare Therapeutic Shoe Demonstration: Was the Demonstration Cost Effective? Final Comprehensive Report

This evaluation indicates that the Medicare Therapeutic Shoe Demonstration produced no definitive evidence that expanding Part B coverage to include shoes for beneficiaries with severe diabetic foot disease would increase total Medicare costs. The demonstration was implemented largely as intended, was successful at increasing ownership of therapeutic shoes, and was instrumental in increasing beneficiaries' use of the shoes when walking outdoors. A therapeutic shoe benefit was added to Medicare Part B as of May 1, 1993, as a result of the demonstration findings.

Accession Number: PB94-121506
Price: A12

Methods for Tracking Volume/Intensity Change: 1991 Data

Using the Medicare 1991 NCH data base, this project develops an episode-of-care-based methodology to monitor service utilization and

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expenditures. This report describes two high-volume Medicare medical conditions—AMI and COPD—and one surgical procedure—CABG. The report includes 12 descriptive tables displaying characteristics of patients, Part A and B episodes of care for selected diagnoses, and Part B expenditure and service utilization for the study conditions.

Accession Number: PB94-122868
Price: A03

National Study of Resource-Based Relative Value Scales for Physician Services: MFS Refinement: Final Report

This report contains the final report on MFS refinement to the RBRVS. The diskette can be ordered as a separate product.

Accession Number: PB94-115094
Price: A99

National Study of Resource-Based Relative Value Scales for Physician Services: MFS Refinement: Documentation and Computer Product

This report contains a diskette copy of the final report on MFS refinement to the RBRVS as well as a hard copy of Appendix G to the report. The diskette can be ordered as a separate product.

Documentation and Computer Product
Accession Number: PB94-104759
Price: A08

Computer Product Only
Accession Number: PB94-500634
Price: D02 computer product

Options for Reforming the Medicaid Matching Formula

This report examines Medicaid's current matching formula and presents a number of options for revising it. The current matching formula is used to determine a State's share of Medicaid financing, and has several weaknesses which may lead to inequitable treatment.

Accession Number: PB94-103553
Price: A05

Physician Hospital Privileges: Implications for a Medical Staff Policy

This report examines physician affiliation patterns with hospital medical staffs and follows development of alternative medical staff payment policies that could strengthen incentives for physicians to control their inpatient service V/I under the MFS. To provide an understanding of the potential for shifting admissions from a higher to lower cost medical staff, this report explores the number of hospitals with which a physician is affiliated as well as the proportion of a physician's practice that occurs in a single hospital.

Accession Number: PB94-168333
Price: A05

Reasonable Charge Impact Studies: Update of Descriptive Tables Developed in "Analysis of Customary Charge Distributions"

This report consists of three major projects. The first is the updating and enhancing of descriptive charge data tables from 1988 to 1991 data. The second is a study evaluating pre-MFS trends in physician caseloads and utilization. The third project is a study to estimate redistribution impacts which occurred as a result of changes in specialty by 53,000 physicians in 1992.

Accession Number: PB94-181724
Price: A14

Refinement of the Relative Value Scale of Physicians' Work

This report began as an examination of ambulatory cardiac monitoring, but was broadened to include a review of the cardiac RVS. The purpose of the study is to examine methods used for evaluating the validity of the RVS. The project consists of two parts: a panel meeting evaluating the validity of the cardiac RVS in the MFS; and a meeting examining the evaluation of validity of the RVS.

Accession Number: PB94-106267
Price: A03

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Regional Variation in the Impact of Medicare Physician Payment Reform

This report finds that pre-MFS physician fee differences are based not only in practice costs, but also in population density, private insurer fees, and physician supply measures. Options for payment reform are presented along with impacts on areas receiving fee reductions.

Accession Number: PB94-114428
Price: A08

Reimbursement Under Uncertainty: What to Do if One Cannot Identify an Efficient Hospital

The objective for this project was to develop a method for identifying an efficient hospital. The need to do so follows from legislation, commonly referred to as the Boren Amendment, that requires the Medicaid program to reimburse hospitals at a rate that is 'reasonable and adequate to meet the costs that must be incurred by efficiently and economically operated facilities.' Satisfying this mandate would thus appear to require the identification of efficient facilities and calculating their costs. The study finds that the data and measurement methodology to identify efficient hospitals are not sufficiently developed to use for rate-setting purposes. Thus, the relevant issue is how to reimburse hospitals given this scenario. The same problem arises in other regulated industries, and the report draws on the industrial organization literature that addresses the problem.

Accession Number: PB94-210176
Price: A04

Report to Congress—Adequacy of Reimbursement Rates to Pharmacies and Its Impact on the Access to Medication and Pharmacy Services by Medicaid Recipients

This *Report to Congress* addresses research questions in two areas: adequacy and access. The major question regarding adequacy is whether State payments are adequate in relation to the costs of dispensing drugs. The major question regarding access is whether there is a relationship between the adequacy of State payment and access. The report finds that, in general, payment to Medicaid pharmacies appears adequate to ensure access.

Accession Number: PB94-187689
Price: A06

Report to Congress—Medicaid Drug Use Review Demonstration Projects

OBRA 1990 mandated that demonstration projects be conducted to assess the cost and cost effectiveness of OPDUR. Abt Associates, Inc. was awarded a contract to provide an independent evaluation of the demonstrations. This *Report to Congress* outlines each project's methodology, progress to date, and future directions.

Accession Number: PB94-187572
Price: A03

Statistical Properties of Physician Surveys—Proxy Response and Survey Error: Additional Evidence From the 1988 Physicians' Practice Costs and Income Survey

This report performs a systematic review of the PPCIS public-use data tape and code book and analyzes the statistical properties of selected national physician surveys. The first analysis is of the accuracy and usability of PPCIS data for conducting analyses. The latter analysis is of specific characteristics of the PPCIS—characteristics associated with physician or proxy response to cost questions, and costs associated with services provided in office versus other settings.

Accession Number: PB94-106275
Price: A06

Study of Coverage Denial Disputes Between Medicare Beneficiaries and HMOs

This project analyzes coverage denial disputes between Medicare HMO enrollees and HMOs to develop a classification of types of disputes and causal or explanatory attributes giving rise to disputes.

Accession Number: PB94-118098
Price: A11

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Toward Profiling Physicians for Inpatient Services: Florida

This report profiles Florida physicians' inpatient services. It is intended as a prototype tool for analyzing physician practice patterns. First, physician services are linked to hospital admissions. Physician service RVUs are summed and case-mix adjusted to create a measure of physician service volume. Additional analyses include physician services by metropolitan area, hospital type, and TOS category. This profiling tool could be used by staffs and others to understand the source of, and to control, costs.

Accession Number: PB94-109808
Price: A03

Updating the Geographic Practice Cost Index: Revised Cost Shares

This report has three primary functions: It supports HCFA's review of the original GPCIs; assesses cost shares in effect from 1992-94; and recommends alternatives for updating the national practice input shares. Section I provides background information; Section II evaluates cost share data sources; and Section III describes MEI cost shares.

Accession Number: PB94-161072
Price: A04

Updating the Geographic Practice Cost Index: The Physician Work GPCI

This report has three primary functions: It supports HCFA's review of the original GPCIs; assesses the Medicare quarter work GPCI in effect from 1992-94; and recommends alternatives for updating the quarter work GPCI. The report describes data and methodology for calculating alternative physician work GPCIs.

Accession Number: PB94-161080
Price: A06

Updating the Geographic Practice Cost Index: The Practice Expense GPCI

This report has three primary functions: It supports HCFA's review of the original GPCIs; assesses the PEGPCI in effect from 1992-94; and recommends alternatives for updating the PEGPCI. Part I includes the employee wage index. Part II includes the office rental index. Part III includes supplies, equipment, and miscellaneous expenses.

Accession Number: PB94-161098
Price: A11

Updating the Geographic Practice Cost Index: The Malpractice GPCI

This report has three primary functions: It supports HCFA's review of the original GPCIs; assesses the Medicare malpractice GPCI in effect from 1992-94; and recommends alternatives for updating the malpractice GPCI. The report includes sections on new data collection, methodological revisions, changes and alternatives, and the effect of replacing population weights with RV weights.

Accession Number: PB94-161106
Price: A05

Use of DRGs by Non-Medicare Payers

This report describes an optional payment system based on Medicare payment methodologies that could be adopted by other third-party payers. The report describes how PPS has been adapted to suit the needs of a wide variety of governmental and private payers. No single approach is found to be dominant. What has emerged appears to be a very flexible payment system in which the only constant is the use of DRGs as a measure of output.

Accession Number: PB94-176518
Price: A05

Use of Medicare Payment Methodologies and Cost Containment Strategies by Medicaid Programs and Private Payers

This study evaluates the extent to which MFS has been used by other payers. Primarily based on a survey conducted by Deliotte & Touche, the study shows that there has been widespread diffusion of MFS.

Accession Number: PB94-139573
Price: A07

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Adoption of Hospital Services: 1963-1989

This study provides a continuous series for each hospital service from 1963 to 1989, using AHA's Annual Survey of Hospitals and Hospital Statistics as the primary data sources. Two trends are evident: growth in diagnostic and therapeutic ancillary services, and growth in outpatient care.

Accession Number: PB93-105849
Price: A03

Alternative Medicare Physician Payments for Surgery Services in Non-Office Ambulatory Settings

This report conducts three analyses. First, an analysis of surgery in three ambulatory settings—physicians' offices, hospital outpatient departments, and ASCs—describes which procedures are performed, where they are performed, and which physician specialties perform them. The second analysis explores differences in procedure payments for high-volume procedures common to all three settings and Medicare payment rules which vary by place of service. The last analysis simulates the effect of enforcing the 60-percent payment limit rule on physician global fees by extending the rule to emergency and ASC services, as well as simulating the effect of moving to the RBRVS of MFS.

Accession Number: PB93-112746
Price: A03

Analysis of Hospital Medical Staff Volume Performance Standards: Technical Report

Implementing a VPS for medical staffs requires a number of technical analyses, including a case-mix measure based on inpatient services and payment or performance adjustors at the medical staff level. This report uses MFS RVU claims data to measure physician service V/I. Deflated physician charges may reflect the historical distortion in the pre-MFS system resulting from physician charging practices. Consequently, the impact of using RVUs instead of charges in the development of the case-mix measure and multivariate analyses of RVUs per admission is examined and compared with prior findings on deflated charges. Data base construction and the development of the case-mix measures are reviewed.

Accession Number: PB93-181964
Price: A04

Analysis of Inappropriate Utilization and Lack of Access for the Purpose of Determining the Medicare Volume Performance Standards

This report discusses optional approaches for defining and measuring appropriate utilization of services and access to care, and how these factors may be taken into account in developing recommendations for the MVPS. Evidence from a literature review of utilization studies, including appropriateness research and studies of geographic variation are presented. Use of consensus panels, patient care outcomes, and the use of epidemiological data are considered as approaches to measuring appropriateness. Approaches in measuring access to care, including the use of potential and actual access measures are discussed. The report concludes that rigorous and systematic measurement of inappropriate utilization and access to care is beyond present capabilities, except possibly on a case-by-case basis for selected procedures.

Accession Number: PB93-109312
Price: A04

Analysis of Proxy Effects in the 1988 Physicians' Practice Costs and Income Survey

This report analyzes the 1988 PPCIS. It examines the effects of allowing proxies to respond to practice cost, revenue, or payer mix questions. This study examines who uses proxies, completeness of proxy responses, and whether there are differences in data reported. Proxy respondents have non-response rates similar to physician respondents. Controlling for other practice and physician characteristics, the authors found that proxies report significantly higher expense data for most cost items. It is impossible to determine, based on information available to the investigators, whether proxy respondents or physicians provide more accurate information. Proxies may offer a number of benefits, such as higher response rates on certain items and conversion of some refusal cases into respondents. However, users are cautioned that there

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are systematic and significant differences in the absolute values of certain cost data reported by proxies on the 1988 PPCIS.

Accession Number: PB93-112761
Price: A03

Assessing Quality of Care for Hospitalized Medicare Patients With Hip Fracture Using Coded Diagnoses From the Medicare Provider Analysis and Review File

This study assesses the validity of using Medicare hospital claims data to identify adverse events following repair of hip fracture. The study identifies adverse events from diagnostic and procedure codes in the ICD-9-CM from claims records and compares them with events identified from medical record abstracts. The study finds many discrepancies between the claims data and the medical record abstracts, and notes that ICD-9-CM codes were less likely to be assigned if the patient was discharged dead. Also noted is that many of the diagnostic codes used by HCFA to define adverse events frequently refer to conditions predating the operation. These conditions are actually co-morbidities rather than adverse events. The study contains several recommendations for improving HCFA's method of identifying adverse events.

Accession Number: PB93-112811
Price: A04

Assessment of Physician Practice Cost Data Needs

This study assesses current (through 1991) and future physician economic data needs, sources, and collection strategies. The study questions addressed include the major needs for physician cost (income) data, the kinds of data required, what data are currently available, the strengths and weaknesses of existing data sources, and priorities for future collections. Major ongoing HCFA needs for data identified were: the MEI, GDCI, NHE estimates, other administrative cost estimates, development of a macro model of the interaction of the health care sector with the rest of the economy, and a wide range of basic research studies. Data strategies that could be pursued include: continuing to periodically field the PPCIS; combining resources with physician organizations that collect data; developing panels and focus groups; or developing cost reports for physician reporting akin to those required of hospitals.

Accession Number: PB93-124733
Price: A03

Beneficiary Attitudes Toward and Experiences With Medicare Demonstration PPOs: Evidence From the Phoenix, Arizona and Orange County, California Structured Discussion Groups

This study describes the four structured discussion sessions with Medicare beneficiaries in each of two demonstration sites, CAPP CARE in Orange County, California, and Senior Preferred in the Phoenix area. The study provides indepth information about beneficiary knowledge, attitudes, choices, and experiences with the two demonstration PPOs.

Accession Number: PB93-116374
Price: A04

Bundling the Fee for Collection and Handling of Blood Specimens With the Office Visit Payment Rate

This report analyzes the distribution of claims and allowed charges for the collection and handling of blood specimens by carrier and physician specialty, and examines alternatives for bundling this service. Four alternatives are outlined for bundling collection and handling of blood specimens with other services. The scheme with the smallest impact on Medicare outlays would bundle blood specimen collection and handling charges with blood tests performed in the office; a second scheme would bundle collection and handling reimbursement with office visits and consults; the third and fourth, respectively, would include bundling collection and handling with both blood tests and office visits and consults, while denying reimbursement for collection and handling of blood specimens, regardless of other services.

Accession Number: PB93-190924
Price: A03

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Can Medicare Cost Reports Be Used for Cash Flow Analysis? The Benefits and Feasibility of a National Data Base on Hospital Cash Flow Statements

This project assesses the feasibility of developing a national data base of hospital cash flow financial health. The assessment has three phases: (1) a summary of State efforts to collect and maintain publicly accessible audited hospital financial and cash flow statements; (2) documentation of acquiring and converting hospital financial data computer tapes from California and Arizona into standardized cash flow information and assessment of the accuracy of the data; and (3) feasibility analysis of using Medicare Cost Reports to assess hospital financial status.

Accession Number: PB93-3220184
Price: A04

Comparing Physician Fee Schedules in Canada and the United States

This report analyzes similarities and differences of physician fee schedules in the four largest Canadian provinces and the 1992 MFS. The first part addresses how service definitions are established and modified, what services are reimbursable, and how fees for individual services are established and updated. The second part focuses on differences between the Canadian and Medicare schedules in defining evaluation and management services, bundling payments for physician services, and adjusting for special circumstances.

Accession Number: PB93-183762
Price: A03

Comparison of Early and Late Responders to the 1988 Physicians' Practice Costs and Income Survey

This analysis attempts to determine whether there are systemic differences between those responding at the tail end of the 1988 PPCIS survey and those responding earlier in the project. The study concludes that care should be exercised in terminating a period prematurely because of systematic differences between early and late responders.

Accession Number: PB93-112787
Price: A03

Concurrent Care During Hospital Admissions Analysis

This study investigates the increasing use of concurrent care during hospital admissions; investigates aspects of physician billing patterns during admissions in 10 DRG sets; and develops criteria for identifying "questionable" visits. In addition, a detailed analysis of concurrent care during CABG surgery is performed. This study shows that hospital visits and consultations by a number of physicians other than the attending surgeon were common. An analysis of the temporal pattern of charges for visits and consults revealed large differences of intensity between time windows.

Accession Number: PB93-132660
Price: A04

Criteria Paper: Issues in Visit-Based Bundling

This study reports a conceptual representation of the equity-efficiency tradeoff in bundling, considers technical and practical issues involved in visit-based bundling, and recommends criteria for evaluating alternative approaches.

Accession Number: PB93-184158
Price: A03

Decomposition of Hospital Cost Inflation by Department

This study examines the internal cost structure of hospitals using the AHA MONITREND data base, which reports volume, cost, labor, and service intensity trends by more than 40 hospital departments. It also describes growth in these departments for the years 1980-88 as measured by expenses per adjusted discharge and total employment, and decomposes inflation into several components, including wages, productivity, and patient intensity. This study concludes that, since 1983, hospital cost inflation has slowed, and that much of the decline can be attributed to slower inflation in the economy and not to PPS. The expectation that the shifts to outpatient settings would bring material savings in total hospital costs has not been realized. Savings from outpatient activity have been offset by falling inpatient discharges.

Accession Number: PB93-105930
Price: A03

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East-West Differences in Hospital Lengths of Stay and Episode Use for Hip Fractures

This report explores factors that might explain differences in hospital LOS between eastern and western States using files providing information related to episodes of hospitalization. Analysis is directed at examining the possible substitution of post-hospital care for extra inpatient days in eastern hospitals.

Accession Number: PB93-105807
Price: A03

Effect of Medicare's Prospective Payment System on Hospital Employment

This study concludes that, on average, PPS had a minor, one-time effect in reducing hospital labor intensity or inefficiency in the 1980s. After PPS1, employment growth resumed an upward trend of about 2.5 percent per year. However, hospitals under greater financial pressure from PPS did limit employment increases more than hospitals under less financial pressure. Also, hospitals converted some of their current "profits" to future increases in employment.

Accession Number: PB93-102291
Price: A03

Effect of Medicare's Prospective Payment System on Hospital Service Diffusion

Using data from AHA's Annual Survey of Hospitals for the 1983-89 period, this study finds little evidence that the Medicare PPS slowed the diffusion of cost-increasing technologies among hospitals. This study concludes that the lack of PPS impact may be due to high hospital profits in the early years of PPS, the Medicare pass-through of capital costs, or heightened competition for patients. The results indicate that hospital case mix and bed size are more important determinants of hospital service adoption.

Accession Number: PB93-102283
Price: A03

Effectiveness of Ambulatory Cardiac Monitoring

This study examines the effectiveness and clinical uses of ACM, focusing on: the diagnosis of cardiac causes of syncope in the elderly; the detection of life-threatening cardiac ischemia in asymptomatic patients after myocardial infarction; and the selection of effective antiarrhythmic drug therapy in patients with malignant ventricular arrhythmias. The study finds that if procedures are sequenced in order of decreasing expected yield and increasing invasiveness, ACM is indicated to establish the likely etiology of syncope. The study finds that ACM is indicated for silent ischema, but is no better than other tests, such as an exercise stress test or thallium scintigraphy. The study found the most cost-effective treatment for antiarrhythmic therapy was the use of electrophysiological studies followed by ACM.

Accession Number: PB93-127678
Price: A06

Effects of Hospital and Environmental Characteristics on Selected Outcomes of Care

The analysis focuses on identifying particular hospital characteristics and environmental factors associated with poor patient outcomes, relying on patient and hospital level data for FYs 1985-88. It addresses three research questions: (1) what hospital and environmental characteristics are associated with unnecessary utilization and poor quality of care; (2) how have risk-adjusted mortality and readmission rates changed since the inception of PPS; and (3) how has the behavior of PROs affected utilization and quality problems? Findings show that surgical admissions were less likely to have a quality problem than medical admissions; quality problems inversely related to scope of services offered and the full-time employee to bed ratio; and quality was higher in hospitals in the northeast than in the south. Findings also show that better outcomes of care occurred at tertiary care hospitals which maintained high occupancy rates, offered a broad range of services, had low proportions of Medicare patients, and were large and government owned.

Accession Number: PB93-105831
Price: A04

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Effects of Medicare's Prospective Payment System on the Financial Performance of Hospitals

This study analyzes effects of PPS rates during a 5-year period on hospital finances. Hospitals with the strongest fiscal pressure from PPS exhibited the best relative degree of economy. Even hospitals with the most unfavorable PPS rates generally fared better under PPS than under prior payment systems. This study estimates that PPS produced an annual savings of $7.5 billion in the fifth year of the program.

Accession Number: PB93-105898
Price: A03

Employment Impacts Associated With Proposed Employer Health Insurance Options

This study estimates the effects of four specific national health care reform proposals on employment. The four proposals examined are: (1) the Managed Competition Act of 1992 (House proposal); (2) Health America (the Senate proposal); (3) California Health Care System for the 21st Century; and (4) the Jackson Hole Group proposal. The study estimates the numbers of jobs that will be affected and the proportions of those jobs that will be placed at risk if each of the four proposed systems is implemented. The demographic characteristics of the workers who are employed in the potentially impacted jobs are also presented. Results indicate that the House proposal will have the smallest impact on employment and the Jackson Hole Group proposal will have the largest. The number of employees whose job characteristics are adversely affected by the four proposals range from approximately 15.7 million to 25.8 million. The proposals differ even more markedly with respect to jobs severely and adversely affected, ranging from a few hundred thousand workers whose jobs will be at risk under the House proposal to more than 20 million workers under the proposal imposing the largest, least voluntary costs on employers.

Accession Number: PB93-184315
Price: A06

Estimating the Utilization Impacts of Hospital Closures Through Hospital Choice Models: A Comparison of Disaggregate and Aggregate Models

This study presents an empirical application of disaggregate and aggregate hospital choice models to a rural hospital market area. The estimated parameters from these models were used to simulate the impact of several possible rural hospital closures on the use of market area hospitals by Medicare beneficiaries. The estimation of two models on the same data base and time period provided quite different results measured by the predictions of odds ratios for the overall market or simulating changes for specific hospital closures. The report concludes that models based on aggregate data should be used with caution.

Accession Number: PB93-190452
Price: A04

Evaluation of the Medicare Catastrophic Coverage Act: Analysis of Massachusetts Births, 1984-1990

This report uses data from hospital discharge abstracts to analyze the characteristics of all births in Massachusetts for the years 1984, 1986, 1988, and 1990. It: provides background on Massachusetts and on the financing of perinatal care for the poor in the state; reviews the data we used for our study, with special attention to the limitations of the data and the constraints that result for our analysis; and provides detailed descriptive results, supplemented by simple multivariate analyses that permit some test of the independent effects of such variables as race, income, and payer.

Accession Number: PB93-112696
Price: A07

Excluded Facility Financial Status and Options for a Modified Payment System

This report updates the financial condition of psychiatric, rehabilitation, LTC, and children's hospitals under TEFRA using data from FYs 1986-88. It provides an overview of TEFRA

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reimbursement and investigates several alternative reimbursement systems in terms of their impacts on each of the facility types. This report concludes that the current system, based on outdated 1982-83 cost-based targets, should be rebased periodically to reflect the true cost of care.

Accession Number: PB93-185940
Price: A06

High-Cost Hospice Care: Final Report

This *Report to Congress* is in response to an OBRA 1989 mandate to '...conduct a study of high-cost hospice care provided to Medicare beneficiaries under the Medicare program, and evaluate the ability of hospice programs participating in the Medicare program to provide such high-cost care to such patients.' HCFA consulted with representatives of the hospice industry, convened a panel of clinical experts, surveyed the clinical literature, and analyzed survey data provided by hospices on patients who used high-cost treatments or were otherwise defined by the hospice as high cost. At the start of the study, persons knowledgeable in hospice indicated that most of the expensive patients were those with difficult or uncontrollable pain. Therefore, much of the focus of the subsequent literature search and the composition of the clinical panel was in the direction of the state of the art in pain management. The findings of the various tasks are reported in the final report.

Accession Number: PB93-120624
Price: A08

High-Cost Medical Staffs: A Policy Option for Controlling the Volume of Physician Services in the Hospital

This report considers high-cost medical staff as an alternative to the national MVPS. This alternative includes all physicians practicing in a hospital as a separate MVPS pool. Efforts to control hospital facility costs serve as precedents for three medical staff strategies. This strategy would involve only a minority of medical staff—those whose practice patterns are clearly outside the norm—and is an incremental approach. This option is designed using a percentage withhold which would be returned in full with interest, returned in part, or not returned at all, depending on medical staff performance. The authors infer that a case can be made that any medical-staff policy to control inpatient physician services may have a positive spillover effect, helping other payers contain their utilization. The primary strength of a medical-staff MVPS is that it combines incentives with structure. Medical staffs have enough structure to implement a cost-containment policy and direct incentives, compared with incentives derived from the national risk pool.

Accession Number: PB93-102267
Price: A05

Hospital Choice Models: A Review and Assessment of Their Utility for Policy Impact Analysis

This report presents conceptual arguments on the strengths and weaknesses of alternative hospital choice models. It includes discussions of the theoretical foundations underlying hospital choice models, previous empirical work, and potential applications for policy analysis, including the designation of EACHs and RPCHs.

Accession Number: PB93-189983
Price: A04

Hospital Closures, Openings, and Mergers During the 1980s

In both descriptive and multivariate analyses, this study evaluates significant changes in status and updates trends in closures, mergers, openings, and ownership changes of non-Federal, short-term, acute-care hospitals, and the characteristics of those hospitals for the period 1980-89. The analyses focus on the factors which cause the loss of patients and, hence, profitability. One important question the study addresses is whether the characteristics of closed hospitals have changed over time. The study finds that inpatient volume declines were greater, and simultaneously costs per discharge rose faster, for hospitals that eventually closed. Smaller hospitals, both rural and urban, were more likely to close than other hospitals. As defined in this study, intramarket hospital mergers totaled 129 during the 1980s, with a peak of 31 mergers during 1988.

Accession Number: PB93-112803
Price: A06

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Hospital Labor Markets in the 1980s

This report presents trends in hospital employment, skill mix, and employee compensation in the 1980s. Hospital employment grew by 18 percent, matching percentage growth in total employment. The skill mix of the hospital workforce increased by 3 percent. The average hourly earnings of hospital employees advanced dramatically in the 1980s, rising by 20 percent compared with a 4-percent decline for all workers. Inflation-adjusted wages of nonprofessional occupations were stagnant. One-half of hospital cost inflation in the 1980s resulted from increases in labor costs and one-sixth from increases in employee compensation.

Accession Number: PB93-105856
Price: A03

Impact of Financial Pressure on Quality of Care in Hospitals

This report analyzes data on more than 200,000 Medicare patients hospitalized during the period 1984-87 to investigate how differences in the financial pressures of the PPS and the prior cost-based reimbursement methodology, both across hospitals and over time, have affected quality of care. The report concludes that hospital mortality is inversely associated with payment levels and margins, and that increased financial pressure may lead to reduction in quality of care for Medicare patients admitted to government-owned or small hospitals.

Accession Number: PB93-105872
Price: A03

Impact of Medicare Prospective Payment on Hospital Profits

This study examines hospital Medicare margins during the first 5 years of PPS. Data show that Medicare margins have fallen from about 14 percent annually in PPS1 and PPS2 to 8.7 in PPS3 and to just 1.4 percent in PPS5. Several conclusions are drawn from these data: Medicare patients have been more lucrative to hospitals; the economic advantage of Medicare reimbursement has almost disappeared over time; Medicare patients have subsidized non-Medicare patients; and hospitals have substantial non-patient revenues that they use to offset patient losses. The data suggest that the large jump in profits during the first 2 years of PPS were due to a vigorous response to increased uncertainty. Once PPS was in place, hospitals began to run down fund balances through negative patient margins.

Accession Number: PB93-105922
Price: A04

Impacts of LTC Supply Differences on Medicare Services Use: A Conceptual Model

This report considers how LTC supply may affect Medicare utilization. A conceptual model for individual utilization of acute and long-term health services is presented which postulates that demand for acute and post-acute health services is at least marginally affected by the amount and type of LTC being consumed prior to the health event, and possibly by the accessibility of LTC in the community. The conceptual model suggests that measures of LTC use and supply can and should be included in studies of Medicare utilization, so that hypotheses about the effects on LTC receipt and access can be investigated. The report presents information concerning the variation in Medicare utilization, and clarifies the distinction between LTC and acute services covered by Medicare.

Accession Number: PB93-184323
Price: A06

Incidence of Adverse Medical Outcomes Under Prospective Payment

This report examines links between prospective payment for hospital care and adverse medical outcomes, using a longitudinal data set of almost 30,000 Medicare recipients, with more than 40,000 hospital admissions, in New England for the period 1981-88. Findings suggest that under PPS, there has been an increase in readmissions and a decrease in inhospital mortality. Much of the increase appears to be due to financial responses by the hospital.

Accession Number: PB93-105864
Price: A03

Integrating Results of Physician Practice Cost Surveys

This study assesses the feasibility of integrating the PPCIS with the AMA's 1989 SMS, to increase the effective sample size. The report presents

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three types of findings: (1) comparability of the PPCIS and SMS survey designs; (2) comparability of the PPCIS survey data; and (3) methodology for combining the two samples, including the development of new weights. The methodology used to combine the two surveys into a single data base is explained. Due to the experimental nature of the project, eight alternative weighting procedures are presented and evaluated. A number of significant differences in the descriptive statistics exist between the two surveys on key variables. However, there are few benchmarks to determine which target more accurately reflects the true population of physicians.

Accession Number: PB93-112753
Price: A05

Inventory of Physician Practice Cost Data Sources

This report provides an inventory of data sources relevant to the economics of physician practice. It provides a listing and description of selected data sources. Physician economics is defined as issues relating to productivity, fees, practice revenue and expenses, net income, payer mix, billing practices, and demographics. The inventory includes abstracts for a total of 30 data sources, representing different sponsors. Each abstract contains the following basic information: description, data, survey elements, response rate, accessibility, contact person, and references.

Accession Number: PB93-124725
Price: A03

Measurement of Services Provided by Physicians Under the Monthly Capitation Payment: A Proposed Study Design

This study assesses: the nature and quantity of physician services provided to ESRD patients in a month; the degree to which these services vary among physicians and the factors affecting their variation; the portion of services reimbursed through the MCP which are not dialysis related; and the relationship between billing practices and the provision of services.

Accession Number: PB93-112738
Price: A04

Measuring Therapeutic Efficiency of Diagnostic Activity in Medicare: An Exploratory Analysis

This report explores the use of Medicare administrative data to measure the efficiency of medical care episodes associated with high-volume, expensive diagnostic procedures. Findings relate frequency of a diagnostic procedure to the frequency of the clinically associated therapeutic or preventive intervention that usually follows. Conclusions indicate that in selected clinical areas, the analysis of yield (ratio of interventions to diagnostic procedures) may be useful for monitoring program efficiency and access of Medicare beneficiaries to important surgical technologies.

Accession Number: PB93-105823
Price: A05

Medicaid Expansions for Pregnant Women and Children: A State Program Characteristics Information Base

This study creates a data set of Medicaid maternal and child eligibility expansions for each State for inclusion in current HCFA evaluations. This report verifies State-specific Medicaid eligibility and maternal and child health program implementation information from available published sources and from direct contact with appropriate sources. Program characteristics included eligibility thresholds for pregnant women and children from April 1987 through 1990; State efforts to streamline or simplify the Medicaid eligibility process; outreach efforts in the State; State efforts to increase obstetrical provider participation; malpractice initiatives; and the effective dates for the introduction of enhanced prenatal services statewide and/or in specific local areas.

Accession Number: PB93-121358
Price: A05

Medicaid: Neonatal Intensive Care Unit Costs

This report identifies important research and policy issues pertaining to Medicaid and NICU costs. Following an extensive review of the

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clinical, cost effectiveness, and policy literature on NICUs, the report provides an overview of technology and delivery systems.

Accession Number: PB93-120566
Price: A06

Medicaid's Utilization of Prescription Drugs and Health Services Among AFDC Children From Birth to Five Years of Age

This project assesses the differences of continuous and discontinuous Medicaid status on health service utilization and expenditures, and studies selected indicators of health status and quality of care for young children who might be affected by enrollment discontinuities. An important objective for the study is the development of a research methodology using life table analyses to examine health services utilization for persons discontinuously enrolled in Medicaid.

Accession Number: PB93-118511
Price: A03

Medical and Surgical Admission Trends for Medicare Beneficiaries: 1981-88

This study reports broad trends in hospital use by Medicare beneficiaries during the period 1981-88. The study also examines trends in hospital admissions. Total admission per 1,000 beneficiaries dropped in recent years. However, admissions with surgery actually rose during this period. The rise in admissions with surgery is especially noticeable for the oldest-old. The study examines changes in New Jersey and Maryland to determine if changing surgical technology in Medicare-waiver States is the most likely explanation for these findings. The study also examines a random sample of individual hospital admissions for 1981-86 and identifies particular procedures that generate the trend.

Accession Number: PB93-105906
Price: A03

Medicare Episodes Involving Hospitalization Death

This report examines whether and how PPS and other influences on utilization of covered Medicare services have altered practice patterns for hospitalization in the 1980s. It also analyzes changes in Medicare use during the last 90 days of life and focuses on the role of PPS in these changes, with findings of decreased proportion of deaths from 51 percent in 1982 to 45 percent in 1986.

Accession Number: PB93-105914
Price: A04

Medicare Payment—Locality to FIPS County Code Cross-Walk for 1992: Computer Product

This report contains a diskette and documentation for the Medicare Part B Payment Locality County Code Cross-Walk for 1992 that was used in the construction of the Medicare GPCI. The Medicare payment localities represent the Medicare carrier and locality configurations on January 1, 1992, when the MFS was implemented.

Accession Number: PB93-503126
Price: D02 computer product

Medicare Prospective Payment and Hospital Closures, 1980-1988

This report provides a descriptive analysis of closures of non-Federal, short-term, acute-care hospitals for the period 1980-88. The study finds that the number of closures has steadily increased since the inception of the PPS; that rural hospitals are more likely to close than urban hospitals; and that hospitals with high shares of Medicaid admissions were more at risk of closure than those with lower Medicaid shares.

Accession Number: PB93-105815
Price: A06

Medicare Use In Rural Areas

This report examines use of Medicare-covered services by urban and rural residents for the period 1981-86, and explores trends in use of Part A and Part B services and the effects of PPS on service use. Among the findings: Relative to urban counterparts, rural beneficiaries are admitted to hospitals more frequently, stay shorter periods of time, and are readmitted more frequently; there is an increased tendency for rural residents to be admitted or transferred to urban hospitals; home health use increased nationally, with no apparent differences between

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urban and rural residents; and seasonal patterns of admission are more pronounced for rural beneficiaries.

Accession Number: PB93-105948
Price: A04

Multiple Physicians Furnishing Surgery

This study uses Medicare claims data from 1986 and 1989 to examine potential issues of overpayment under MFS resulting from unbundling or overlapping of discrete surgical procedures. Thirty-three major procedures were chosen for analysis from a list of 200 high-cost CPT-4 procedures provided by HCFA.

Accession Number: PB93-216133
Price: A06

National Study of Resource-Based Relative Value Scales for Physician Services: Phase 3: Final Report

During Phases I and II of the RBRVS study, large-scale surveys were used to generate relative values for services that were not surveyed in Phases I or II. In addition, pre- and post-service work estimates were revised for a large number of services. This submission contains the final report, including appendices A-D and F. The survey data appendices are a separate submission.

Accession Number: PB93-144418
Price: A99

Accession Number: PB93-502698
Price: D05 computer product

National Study of Resource-Based Relative Value Scales for Physician Services: Phase 3: Final Values and Documentation (for Microcomputers)

This submission contains the final values and documentation.

Accession Number: PB93-502706
Price: D05 computer product

National Study of Resource-Based Relative Value Scales for Physician Services: Phase 3: Survey Data Appendices

This submission contains the survey data appendices.

Accession Number: PB93-144400
Price: A99

Packaging Outpatient Physician Services: Final Report

This report evaluates four approaches to packaging Medicare outpatient services on a multiple-visit or episode basis of care. The condition-related outpatient packages are: (1) laser eye surgery; (2) podiatric services; (3) cardiac testing; and (4) cancer treatment. Actual payment data were used to simulate the distributional effects of paying Medicare physician providers on an all-inclusive, single fee basis. The report uses 1988 data from Arizona, Connecticut, Georgia, Kansas, and Washington to simulate the impacts of the four packaging alternatives. The research concludes that two models—podiatric services and cancer treatment—have significant potential for future demonstration projects or program implementation. The study recommends that outpatient packaging be done on a very select basis with customized development focusing on clinical and practice dimensions of the condition involved.

Accession Number: PB93-114601
Price: A07

Patterns of Health Care Utilization in the Non-Elderly Medicaid Population of Selected States

This study examines patterns of utilization for more than 130 inpatient conditions and selected ambulatory procedures in a sample of States. It examines whether treatment and procedures are performed more in the Medicaid population than in the non-Medicaid population, and whether these treatments and procedures are performed more in one geographic area than another within the Medicaid population.

Accession Number: PB93-184836
Price: A13

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Persistence of Financial Vulnerability in U.S. Hospitals: 1970-87

Using data from 1970 through 1987, this study reports on work in progress to: define alternative measures of financial vulnerability that capture persistent or chronic problems in hospitals' financial health; and relate these vulnerability measures to outcomes, including measures of patient care volume and closure. Exploratory analysis shows that historical financial and utilization information are predictors of the probability of hospital closure.

Accession Number: PB93-102275
Price: A03

Physician Fee Levels: Medicare Versus Canada

This report compares the 1992 MFS payment levels with the fees paid in Canada's four largest provinces. Indexes of relative fees were created for all services and for categories of services. They find Canadian fees to be 59 percent of Medicare fees, on average. Canadian fees are 60 percent of Medicare's for evaluation and management services, 53 percent for procedures, and 73 percent for imaging. Differences are much smaller for office visits than for hospital visits. Fee levels are most similar for advanced imaging and most different for orthopedic procedures. The report notes that despite much lower fees, the supply of physicians in Canada is not measurably lower than that in the United States.

Accession Number: PB93-184125
Price: A03

Physician Studies—Growth in Physician Services: Final Report

This is a study of growth in physician services from 1986-88, with emphasis on significant physician expenditures, patterns, and trends. Areas studied were national and local Medicare carrier areas associated with high-volume office and hospital visits, surgical procedures, and diagnostic and lab tests. Changes in utilization measures and data on eligibility and users are presented. There was a 16-percent growth in the number of services per eligible. The gross number of services increased 19 percent and the number of services per user increased 11 percent. Allowed and billed charges increased 17 percent. Growth rates were generally higher for carriers in the south and southwest for surgical and lab services and services provided by specialties.

Accession Number: PB93-126746
Price: A11

Physician Studies—Growth in Physician Services: Final Report—Attachment 1: Supplemental Tables (Volume 1)

Table 1 – Denominators: Impacts of Adjustments for HMO Beneficiaries, Border Crossers, and Medicare Crossovers, 1986-88: National and Carrier (22 pages)

Table 2 – RVUs for HCPCS Level 1 (CPT-4) and Selected Level 2 Codes, RVUs, and Source of the Value (294 pages)

Accession Number: PB93-126704
Price: A14

Physician Studies—Growth in Physician Services: Final Report—Attachment 1: Supplemental Tables (Volume 2)

Table 3 – Expanded Carrier Distribution on Use of Modifiers: National and by Carrier, 1986-1988 (585 pages)

This table is a frequency distribution of Medicare allowed charges and percentages by primary modifier; service units by primary modifier; and allowed charges by secondary modifiers, for the Nation for 1986-88. The games variables (charges and services) are then repeated by Medicare Part B carrier for the same years.

Accession Number: PB93-126712
Price: A25

Physician Studies—Growth in Physician Services: Final Report—Attachment 1: Supplemental Tables (Volume 3)

Table 4 – National Allowed Charges With and Without Modifiers for 26 Diagnostic Procedure Codes and Groups

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Table 5—Provider File Distribution
This table presents two sets of distributional data from the BMAD beneficiary file based on a 1-percent random subsample of line items.

Set 1—National Distributions of BMAD Provider File Line Items, 1986-88
Frequencies for most of the fields in the provider file line items records are presented for 1986-88. Prevailing charges, geographic location, and anesthesia unit fields were omitted.

Set 2—Distributions of Selected BMAD Provider File Data Elements Aggregated by Provider I.D. Numbers, National and by Carriers, 1986-88
Frequencies for the Nation and by carrier are shown for type of provider, HCFA specialty code, physician/ supplier number indicator, and number of physicians/suppliers.

Accession Number: PB93-126720
Price: A16

Physician Studies—Growth in Physician Services: Final Report—Attachment 2: Table Series 1 Through 6

Table 1—Carrier Tables (393 pages)
Changes in number of services, RVU allowed charges, and billed charges: national and by carrier, 1986-88. By assignment, place of service, and specialty.

Table 2—Surgery-Related Services (18 pages)
Changes in number of services, RVU allowed charges and billed charges, 1986-88. By assignment, place of service, and specialty.

Table 3—Selected Individual Procedures and Procedure Groups (55 pages)
Changes in the number of services, RVUs, allowed and billed charges, 1986-88, for type of service (office and hospital visits, consultations, procedures, families) and selected lab tests by assignment, place of service, and specialty.

Table 4—20 Procedures Accounting for the Largest Percent of Service (32 pages)
Medical procedure groups, surgical procedures, X-ray procedures, and lab procedures. By assignment, place of service, and specialty.

Table 5—20 Procedures Accounting for the Largest Percent of Total Charges (32 pages)
Changes in number of services and RVUs, by assignment status and place of service for medical, surgical, X-ray, and lab procedures, by assignment status, place of service, and specialty.

Table 6—Provider Tables (118 pages)
Changes in provider numbers, beneficiary/ provider number combinations, services, RVUs, allowed charges, and billed charges for 1986-88, by carrier.

Accession Number: PB93-126738
Price: A99

Pricing Technologies Under Medicare: Methodological Options and Selection Criteria—A Background Paper

This report presents an overview of possible methodologies to price new medical technologies and reprice existing technologies covered under Medicare. The advantages and disadvantages of six possible but not mutually exclusive alternatives are described. These methodologies include three centered on costs and three methodologies that attempt to incorporate value and other factors into the pricing decision in addition to costs. Criteria that could be used in selecting technologies for pricing using these methodologies are suggested. The study indicates that it would be possible to identify technologies with pricing problems relatively cheaply and easily and make repricing decisions on the basis of systematic reviews rather than on an *ad hoc* basis.

Accession Number: PB93-108991
Price: A03

Problems in Determining a Hospital's Level of Uncompensated Care

This report summarizes issues and trends related to uncompensated inpatient care in hospitals, the burden of uncompensated care on hospitals, and the implications of uncompensated care for cost-shifting across patients. Several issues critical to obtaining accurate and conceptually valid uncompensated care data are represented. An evaluation of the utility of Medicare Cost Reports, AHA Annual Survey data and hospital data sources in 10 States is

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presented, including extended evaluations of uncompensated care data collection in Florida and Tennessee. Several recommendations are directed toward improving the quality of uncompensated care data collection.

Accession Number: PB93-182012
Price: A08

Psychiatric Codes and Billing Patterns

This study provides a description of billing patterns to the Medicare program for psychiatric services by carrier, specialty, type of practitioner, and region. In addition, the research investigates the billing of non-psychiatric services by psychiatrists, and a descriptive analysis of psychiatric services billed by beneficiary characteristics is presented. This analysis describes the overall growth rate of volume, submitted charges, and allowed Medicare payments for both psychiatric services and non-psychiatric services, by type of practitioner, carrier, and beneficiary, from 1987 to 1990.

Accession Number: PB93-191690
Price: A11

Reanalysis of Item Non-Response Rates in the 1988 PPCIS: A Technical Memorandum

This memorandum presents a reanalysis of item non-response rates in the 1988 PPCIS and supplements the 1988 PPCIS Handbook. Earlier calculations of non-response rates may overstate the number of usable numeric responses available for analysis because of exclusion of out-of-range and uncodeable items from the definition of item non-response by NORC. Two types of non-response rates have been calculated: question-level item non-response and case-level item non-response. The revised item non-response rates are slightly lower than the original rates when combined items are excluded, due to the extensive cleaning performed.

Accession Number: PB93-112779
Price: A03

Recruiting and Retaining Physicians in Small Rural Hospitals—Volume I: Study Design, Methods, and Findings

This study provides a review of the literature on physician recruitment strategies for rural hospitals. The report also includes a set of regression models indicating the number of physicians appropriate for a rural county according to selected socioeconomic and demographic variables. The report's final section consists of in-depth case studies of 18 rural hospitals, one-half successful in recruiting physicians and one-half unsuccessful.

Accession Number: PB93-191096
Price: A07

Resource-Based Relative Value Scales for Physician Services, A National Study, Phase III: Final Report

Phase III generates relative values for services that were not surveyed in Phase I or in Phase II. This document contains the final report, including appendixes A-D and F. The survey data appendixes are a separate submission.

Accession Number: PB93-144418
Price: A99

Resource-Based Relative Value Scales for Physician Services, A National Study, Phase I-II-III: Final Values and Documentation

During Phases I and II of the RBRVS study, large-scale surveys were used to generate relative work values. In Phase III, pre- and post-service work estimates were revised for a large number of services. This report contains the final values and documentation.

Accession Number: PB93-502706
Price: A99

Resource-Based Relative Value Scales for Physician Services, A National Study, Phase III: Survey Data Appendices

Pre- and post-service work estimates were revised for a large number of services. This document contains the appendixes.

Accession Number: PB93-144400
Price: A99

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Resource-Based Relative Value Scales for Physician Services, A National Study, Phase III: Survey Data and Documentation

Pre- and post-service work estimates were revised for a large number of services. This document contains the survey data and documentation.

Accession Number: PB93-502698
Price: A99

Screening Criteria for Outpatient Drug Use Review

This project develops screening criteria for use in outpatient drug use review programs. Criteria cover eight groups of drugs that account for a large proportion of the outpatient prescriptions paid for by Medicaid. The groups chosen by the National Advisory Council included: angioy-tensin-converting enzyme inhibitors, antidepressant drugs; antipsychotic drugs; benzodiazepines; beta blockers; calcium channel blockers; digoxin; histamine hy-receptor antagonists; and nonsteroidal anti-inflammatory drugs.

Accession Number: PB93-216125
Price: A07

Service Limitation Options for Limited Service Rural Hospitals

This report presents an alternative to an LOS limit for defining services in limited-service rural hospitals, such as the RPCH. The analysis indicates that small rural hospitals: admit patients in a limited number of DRGs, representing low-intensity conditions; transfer few cases to other hospitals; and treat many patients whose LOS exceeds 3-4 days. The report proposes an alternative service limitation based on DRGs for categorizing patients, relying on extensive QA and utilization review by PROs. Unlike the current 72-hour LOS limit for RPCHs, the proposed method is flexible and features a clinical basis for approving care, making it palatable to providers.

Accession Number: PB93-185981
Price: A04

Setting Medicare Volume Performance Standards for Large Primary Care Medical Practices

This study examines alternatives to permit physician practices to opt out of the national MVPS as legislated by the physician payment reforms of OBRAs 1989 and 1990. Medicare data for 1988-90 for a sample of 122 medical practices in California, Pennsylvania, New Jersey, and Massachusetts were studied. Three separate categories of services were defined: (1) only services within a practice; (2) all MVPS services (limited Part B), regardless of provider; and (3) all Medicare services (Parts A/B), regardless of provider. Average annual reimbursements per patient seen for each provider were compared for 1989 and 1990 to assess stability over time.

Accession Number: PB93-190353
Price: A04

Small Area Variations in Hospital Utilization: The Role of Physician Characteristics

This report presents an econometric model designed to assess the relative influence of physician practice style and local characteristics in accounting for cross-country differences in Medicare utilization. Data were derived from three sources: (1) Medicare Part A claims; (2) the AMA Physician Master file; and (3) the ARF. The report provides an extensive literature review on variations in the utilization of health care services across geographic regions.

Accession Number: PB93-105880
Price: A03

State-Based Survey of Malpractice Premiums: Implications for Medicare Physician Payment Policy

This study provides HCFA with a set of premium data, including the major companies selling malpractice insurance to physicians in each State. This report reviews the data collection process and describes the construction of the premium data base. The composition of the data in terms of types of companies is compared with HCFA's data. These data are used to compute the rate of change in premiums over

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the years covered for all companies, and for physician-owned and for-profit companies separately. These results are contrasted with HCFA's estimates for the same period. Finally, an MGPCI based on the newly collected data, but following the same conceptual approach as used in the index contained in the MFS, is computed.

Accession Number: PB93-190437
Price: A03

Status of the Medicare PPO Demonstration—Early Implementation Experience of: CAPP CARE, Family Health Plan, HealthLink, CareMark

This report describes the pre-implementation experience of four of the five PPOs in the Medicare Physician PPO demonstration. The description of each PPO includes the following: design of the PPO's benefit package, including incentives to enroll and to use network providers; marketing approaches; criteria and process for selecting network providers; utilization management procedures; and quality assurance procedures.

Accession Number: PB93-118057
Price: A05

Study of Factors Affecting Physician Remuneration in Staff Model HMOs and Group Practices

This study examines the nature and extent of physician payment differentials in a variety of physician employment settings. Phase I examines physician payment mechanisms in staff model HMOs, and Phase II consists of a mail survey of a small sample of physician group practices to identify criteria that physicians have accepted as important determinants of their income. The results obtained in Phase I indicated that years of experience, specialty, administrative duties, and board certification status were the most important determinants of physician base salaries. Productivity, volume, and quality of care were used more frequently in determination of bonus payments. Results of the Phase II survey of group practices show that revenue generated for the group was the most frequently used criterion; compensation for administrative duties and years of experience with the group were also common criteria.

Accession Number: PB93-184133
Price: A05

Technical Appendix to "Technology Case Studies: Physician Reaction to Price Changes"

This project addresses the question of whether physicians responded to the OBRA 1987 price changes, and has four major components: (1) technology case studies were performed and provide a discussion of technological changes which occurred during the 1980s and which may have influenced the utilization of these procedures independent of the reimbursement change; (2) changes in the number of "overpriced" procedures during the 1985-89 study period were analyzed; (3) changes in the overall pattern and cost of health care services provided in association with six of the overpriced procedures were analyzed; and (4) a provider-level analysis plan was designed to examine the nature of individual physician response to the price reductions.

Accession Number: PB93-127777
Price: A11

Technology Case Studies (Physician Reaction to Price Changes): Final Report

This report compliments the quantitative study of physician reaction to price changes by assessing qualitative and non-price factors for each of 12 procedures whose Medicare reimbursement was reduced by OBRA 1986 and OBRA 1987. A technology case study for health policymakers without clinical backgrounds is produced for each procedure which includes an overview of the relevant anatomy and disease processes, followed by a description of the surgical procedure, general indications, and possible complications. Technological changes which occurred in the 1980s which may have influenced utilization of these procedures during the 1985-89 study period are analyzed. The intent of these studies is to provide a clinical background to interpret physician response to the substantial price reductions for effected procedures.

Accession Number: PB93-114593
Price: A06

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Trends in Patterns of Post-Hospital Service Use and Their Impact on Outcomes

This study examines the effects of PPS on the following: patterns and trends of service use, and the effect of changes in these factors on patient outcomes, including rehospitalization risks, use of post-acute care, and mortality. The study found a decline in the utilization of hospital services with no offsetting increases in substitute services. The study concludes that the savings attributable to PPS were not diminished to any great degree by expenditure increases in other services examined. Additionally, it was reported that reductions in service use did not appear to represent a degradation of quality of care as measured by mortality and rehospitalization risks.

Accession Number: PB93-112795
Price: A03

Trends in Physician Income, 1978-1988

This study shows that the real net income of all physicians increased from 1983 to 1988. The largest increases were for orthopedic surgeons, cardiologists, ophthalmologists, and cardiothoracic surgeons. Changes in age, gender, and specialty mix explain only a small amount of the income gains. In addition, greater physician work accounts for only a small amount of the rising incomes. A greater quantity of physician services provided and higher profit per service have been major factors in accounting for income gains. Finally, the shift from inpatient to outpatient services has benefited physicians financially.

Accession Number: PB93-134005
Price: A06

Variations in Anesthesia Time by Hospital Teaching Status and Geographic Location

This report examines variations in anesthesia time for Medicare surgical procedures according to hospital teaching status and geographic location. Both descriptive and multivariate analyses are performed.

Accession Number: PB93-120558
Price: A04

Variations in the Management of Myocardial Infarction

This report examines variations in area practice patterns related to physicians' practice style and patient characteristics in the management of myocardial infarction cases. This report also examines the variations' impact on cost per case for 342 Medicare beneficiaries in the States of Washington and Wisconsin in FY 1986.

Accession Number: PB93-219970
Price: A06

What is the Bottom Line? Exploration of Alternative Measures of Hospital Financial Health for Policy Research

This report provides a conceptual framework for the interpretation of profit- and cash flow-based measures of non-profit hospital financial performance and analyzes a data set of standardized, audited financial statements for hospitals in five States. The report recommends the review of the quality of hospital financial data it receives and the development of a central repository of audited hospital financial statements as a resource for public policy researchers seeking to understand and explain hospital financial behavior.

Accession Number: PB93-216299
Price: A05

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Allocating Practice Costs

This project explores alternative conceptual and empirical approaches for determining the values of practice cost (of purchased inputs) and malpractice cost RVU components on a procedure-specific basis. The overhead cost allocation problem is primarily one of deciding which basis will be used for allocation. The two primary candidates considered here are incentive neutrality (to providers) and equity (across providers). However, other objectives were also considered: cost containment, encouragement of certain types of procedures and discouragement of others, and long-run allocation of physician manpower across specialties.

Accession Number: PB92-172964
Price: A05

Analysis of Medicare Customary Charge Distributions

This project tests the feasibility of effectively and efficiently acquiring physician pricing data on customary charges. In the initial phase, data files containing CPR pricing and provider identification information were obtained. The second phase entailed acquiring additional data files on Part B claims experience for the original study States. The third phase expanded the study to include pricing and claims data from additional States. The final phase involved simulations of the aggregate and redistributive effects of implementing the MFS and acquiring and validating updated carrier CPR pricing files.

Accession Number: PB92-115914
Price: A04

Analysis of Variations in Anesthesia Payments: Time Units

This study uses ANOVA on 1989 Medicare Part B claims data to determine the explanatory power by CPT surgical and anesthesia codes with respect to anesthesia time. It also presents distributions of anesthesia time units by anesthesia and surgical codes.

Accession Number: PB92-131432
Price: A12

Assessing the Feasibility of a Cost-Effectiveness Analysis of the Medicaid Expansions for Infants, Children, and Pregnant Women

This project examines the feasibility of undertaking cost-effectiveness studies of the Medicaid expansions designed to increase access to health care for pregnant mothers and children. This report incorporates a brief review of the literature related to the policy rationale and implementation experience of the expansions; a background discussion of the conceptual and methodological issues involved in carrying out cost-effectiveness studies; and a summary of the conclusions and recommendations of an expert panel which found that components of cost effectiveness studies of the expansions be given a lower priority until a more complete foundation is developed. Key items in the panel's recommended research agenda are studies of shifts in the financing and delivery of pregnancy-related care, as well as evaluations of the expansions' implementation with a focus on improving operational efficiency.

Accession Number: PB92-148980
Price: A07

Case-Mix Outcomes and Resource Use in Nursing Homes

This report studies variations in outcomes for nursing home residents and relationships between case-mix adjusters and quality-based-outcomes measures. Studied were a population of residents newly admitted to nursing homes with several different cross-sectional samples of residents in different States. Insights into the conceptual, methodological, and operational issues associated with designing and implementing a case-mix adjustment system for the assurance of quality care in nursing homes are provided.

Accession Number: PB92-124403
Price: A09

Comparison of Medicare Physician Fees, Physician Charges, Fees of Other Payers, and Model Medicare Fee Schedule Payments

This report compares 1984 physician fees, Medicare payments, and private insurance payments. It concludes that Medicare payments under MFS would increase the difference between Medicare and private-payer payments

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for survey, but reduce it for medical visits. The difference will also be narrowed in smaller metropolitan areas. The report caveats that the simulations do not take into account OBRA 1990 changes or changes in MFS since September 1990.

Accession Number: PB92-128362
Price: A08

Develop and Demonstrate a Method for Classifying Home Health Patients to Predict Resource Requirements and to Measure Outcomes

This report describes a classification method developed to predict resource requirements and measure outcomes of Medicare patients in certified HHAs. Data on 73 dependent variables were collected from the home health records of 8,961 recently discharged Medicare patients drawn from a national sample of 646 certified HHAs, stratified by size, ownership, and geographic location. Additional products of the study include descriptive findings on Medicare patients, services and agency characteristics; predictive findings on the relationship between measures of resource use and predictors of resource requirements; and schemes for coding nursing diagnoses and nursing interventions.

Accession Number: PB92-177013
Price: A16

Economy and Efficacy of Medicare Reimbursement for Preventive Services

This report presents findings from the North Carolina Medicare Preventive Services demonstration. A randomized field experiment was conducted to assess the cost savings and improvements in health-related quality of life associated with the introduction of clinical screening services and health promotion counseling under Medicare reimbursement for patients 65 years of age and over. Beneficiaries receiving interventions experienced small, positive gains in health and quality of life indicators relative to control patients at the 2-year followup. Reimbursement and organization of the intervention increased the delivery of clinical screening procedures, but there was a lack of followup for abnormal findings. The study supports the conclusion that preventive health services intervention is reimbursement-cost neutral.

Accession Number: PB92-204189
Price: A05

Efficacy of Nursing Home Pre-Admission Screening

This study evaluates the efficacy of PAS as it is currently employed in selected State programs, with special focus on Medicaid 2176 HCBS waiver programs. Major analyses conducted include: (1) an evaluation of the predictive validity of screens from Oregon, Connecticut, Virginia and New York using measures of sensitivity and specificity (and associated measures of the proportion of false positive and false negative screens); (2) an analysis of the goodness of fit of a model predicting nursing home admission, when age, gender, race, and place of residence are eliminated from the model; and (3) an analysis and refinement of Connecticut's PAS instrument, along with the development of alternative decision rules which invoke different thresholds.

Accession Number: PB92-135805
Price: A10

End Stage Renal Disease, 1989

This *HCFA Research Report* presents statistics concerning recent trends in ESRD treatment and detailed discussions of selected health issues involving the ESRD population. Several tables in this report emphasize trends and comparisons over time, making this report a standard reference on the Medicare ESRD population and on ESRD treatment patterns.

Accession Number: PB92-128974
Price: A05

Evaluation Design Report for the Medicare Physician Preferred Provider Organization Demonstrations

This report has two principal components: an assessment of the implementation experience prior to startup and during the initial 6 months of the demonstration; and an evaluation of site-

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specific impacts of the demonstration, including analyses of beneficiary choice and biased selection, beneficiary use and costs of services, and provider practice patterns.

Accession Number: PB92-236025
Price: A08

Evaluation of the Arizona Health Care Cost Containment System Demonstration: First Implementation and Operation Report

This is the first report covering the issues involved in the implementation and operation of ALTCS. This report provides an overview of ALTCS during the first 18 months of operation and summarizes findings and policy implications for implementation and operation issues.

Accession Number: PB92-145671
Price: A21

Evaluation of the Arizona Health Care Cost Containment System Demonstration: First Outcome Report

This report covers outcome issues being studied as part of the evaluation of the AHCCCS. This evaluation pertains to the ALTCS, which became operational in January 1989. Three separate outcome analyses are included in the report: (1) cost; (2) utilization, access, and satisfaction; and (3) quality of care.

Accession Number: PB92-154871
Price: A14

Final Report on Qualitative Analysis of the Program of All-Inclusive Care for the Elderly (PACE)

This report covers an 18-month study to qualitatively evaluate the PACE demonstration during site predevelopment and early implementation stages. The PACE demonstration seeks to replicate a model of capitated, comprehensive, risk-based acute and LTC for the frail elderly. Findings regarding replicability are discussed.

Accession Number: PB92-178409
Price: A04

Final Report of the Texas Nursing Home Case-Mix Project

This project develops a prospective payment methodology based on case mix for the Texas Medicaid Nursing Home Program. Objectives were the development of specialized forms and procedures to collect information on the functional abilities, service needs, and resource utilization of nursing home clients. This information was used to: develop a case-mix classification system; develop and analyze different case-mix indexes; select the indexes which best account for variations in the cost of caring for different types of nursing home patients in Texas; and provide the appropriate incentives to improve quality and access to services.

Accession Number: PB92-115021
Price: A05

Geographic Border Crossing: Implications for Volume Performance Standards

This report presents information on geographic border crossing for the use of Medicare physician services. The results find that there is substantial geographic variation across both States and urban and rural areas in border crossing to seek services. There is more border crossing across smaller geographic areas than among States. Predominantly rural areas tend to be major importers of services, while urban areas, on average, export services. Border crossing tends to be greater for high technology services, such as advanced imaging, cardiovascular surgery, and oncology procedures. Implications for future MFS refinements are discussed.

Accession Number: PB92-128586
Price: A04

Geographic Variation in the Volume and Intensity of Medicare Physician Services in 1988: A Descriptive Analysis

This study presents a comprehensive description of the extent of cross-sectional geographic variation in Medicare physician service use rates across all services and across the United States. There are substantial geographic differences in V/I of physician services provided to Medicare beneficiaries, varying by a factor of 3.5 from highest to lowest and by 1.7 in the 95th to the 5th percentile. The degree of variation varies across service categories with substantially more variation for consultations, home and nursing home visits, minor procedures, oncology services, and laboratory tests than for office visits, all categories of major procedures,

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endoscopies, and standard imaging. Implications of these findings with regard to VPS policy are discussed.

Accession Number: PB92-227214
Price: A03

Goals and Strategies in Financing Long-Term Care

This study draws from the disciplines of economics and sociology to define mandatory and variable objectives for financing LTC. The objectives are applied to public policies designed to overcome impediments to market transactions for funding and delivering LTC services. The authors recommend that public policies be designed to remove informational impediments to the emergence of LTC insurance markets, and to provide information about new services and assist in introducing these to the market. Application of the objectives to public sector financing and/or delivery of LTC services is discussed.

Accession Number: PB92-178383
Price: A09

Growth in Medicare Inpatient Physician Charges Per Admission, 1986-1989

This study analyzes growth in Medicare inpatient physician services between 1986 and 1989. Growth is reported by specialty, type-of-service, hospital type, and DRG. The study explores the number of physicians providing services during the admission.

Accession Number: PB92-227149
Price: A04

Guidelines for Minimal Post-Hospital Care of Elderly Medicaid Patients: Instruction Manual for Use in Hospital Discharge Planning

This project produces manuals intended to be used in hospital discharge planning and HHA QA programs. When applied to discharge planning, aftercare guidelines are used prospectively in determining minimal care specifications comprising patients' immediate post-hospital care treatment plans. Home health care QA involves use of guidelines to retrospectively evaluate whether specifications were met in the provision of post-hospital care. Each guideline is described in terms of its major components, which include: care need category, patient characteristics, minimal care specifications, and potential adverse outcomes.

Accession Number: PB92-189174
Price: A08

Hospital Closures, Financial Status, and Access to Care: A Rural/Urban Analysis

This study addresses why hospitals close and how closures affect access. Hospitals that closed between 1981 and 1988 were compared with the admissions, costs, and revenues of similar hospitals that remain open. A patient-level analysis compares patients of open and closed rural hospitals along the following dimensions—diagnostic mix, severity of illness, and patterns of care. The study found that: (1) PPS did not increase the relative odds of a hospital closing, holding constant profitability and other factors; (2) controlling output levels and mix, lower revenues, not higher costs, are the main reason for closed hospitals' lower profits; (3) closed hospitals appear to provide less complex care and to treat more of the oldest-old (85 years of age or over), disabled, and beneficiaries who are other than white; and (4) the closing of rural hospitals had minimal effects on access to subsequent hospital care for Medicare beneficiaries.

Accession Number: PB92-222462
Price: A06

Hospital Demand for Nurses

This report presents cross-section estimates of hospital demand for RNs and nursing personnel mix using primarily 1982 data. It also discusses factors influencing hospital demand for nurses—hospital outputs, nurse wage rates, substitutability of LPNs and ancillary nursing personnel for RNs, and market competition. The authors conclude that one response of hospitals to the PPS and greater price sensitivity by private third-party payers has been a movement toward greater use of RNs as a more efficient use of nursing personnel.

Accession Number: PB92-233048
Price: A03

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Hospital Medical Staffs and Medicare Volume Performance Standards: Analytic Foundations

This is an empirical analysis of the hospital medical staff as a potential risk pool for setting separate VPS, as an alternative to the national standards mandated by Congress under OBRA 1989. Using 1987 5-percent claims data, physician charges per admission and relative physician weights for each DRG were calculated. The impact of various policy options on distributions of physician (medical staff) charges per admission by type of hospitals were assessed by both univariate and multivariate analyses. Drawing from the hospital cost function literature, the study specifies a general model and a policy model. The general model explains 83 percent of the variation in mean physician charges before case-mix adjustment; the policy model explains 39 percent of variation after controlling for case-mix and other factors. The policy model indicates that mean physician changes are higher in RRCs and SCHs.

Accession Number: PB92-163252
Price: A09

Hospital Service and Productivity Databook: 1963-1990

This databook is a compilation of AHA data covering the last 25 years of hospital performance, with a special emphasis on the 1984-90 period after the implementation of PPS. The databook summarizes the changing structure of the industry including the decline in the number of short-term hospitals and beds, and the rapidly expanding scope of services offered. Overall trends in expenses, revenues, and selected measures of utilization during the 1965-89 period are shown. The growth in hospital employment, decomposed by hospital ownership and over 30 occupational categories, is tracked. Related trends in capital inputs are constructed and displayed. The report concludes with numerous tables describing trends in labor and total factor productivity—primarily in the 1980-89 period as well as data for 1980-90 productivity and intensity trends for over 40 hospital cost centers.

Accession Number: PB92-121037
Price: A05

Hospital Vulnerability to the PPS

This report analyzes the two principal causes of Medicare operating losses among hospitals: hospital inefficiency and failure of PPS methodology. It discusses difficulties in distinguishing between losses due to inefficiency and those due to payment methodology, and describes hospital behavior modifications to reduce Medicare losses and alternatives to absorbing Medicare losses.

Accession Number: PB92-239102
Price: A03

Impact of the Growth in Ambulatory Procedures and Diagnostic Services Upon Inpatient Care

This report studies the relationships between ambulatory care and inpatient services and their effects on hospital decisions about the outpatient and inpatient care they offer. It also provides an analysis plan for future study of the relationship between ambulatory care and physician services. Based on a literature survey, the report identifies incentives affecting linkage between the provision of ambulatory services and hospital inpatient services, with special emphasis on Medicare and other payer reimbursement policies. It provides three related conceptual models to analyze the relationship between inpatient and outpatient care: a hospital's decision to invest in ambulatory capacity; the relationship between diagnostic testing and therapeutic services; and the decision to invest in outpatient diagnostic equipment. Analysis shows that Medicare PPS increases demand for outpatient care by restricting the availability of inpatient services.

Accession Number: PB92-205574
Price: A09

Interventions to Reduce Drug-Related Reactions Among Community-Resident Elderly Medicare and Medicaid Patients

This study represents a first step towards implementing an ADR reduction research program. The existing literature was reviewed in order to identify interventions that could achieve reductions in the costs associated with ADR reduction research programs among

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elderly persons residing in the community. This study provides some historical background on the government regulation of drugs, a definition of ADRs, a discussion of the benefits of reducing ADRs, and an assessment of the factors associated with interventions.

Accession Number: PB92-145911
Price: A05

Laboratory Industry Technology, Productivity Changes and Medicare Payments in Different Provider Settings

This study examines the effects of technological advances on the cost of lab services in various provider and supplier settings. The following are the findings of the study. First, based on the findings for hematology, technology appears to be an important source of cost economies where key labor tasks can be successfully automated. The downsizing of instruments per se does not appear to generate marginal cost savings, although it may permit existing tests to be conducted at reduced scales of output without suffering serious diseconomies. Second, the profitability of laboratory testing varies widely across tests and cost methodologies, suggesting that payment reforms to align costs with revenues should be conducted on a test-by-test basis, and that close attention should be given to the choice of overhead cost-allocation methodology. Finally, the relative costs of testing in the physician's office using smaller instruments, as compared to outpatient or commercial laboratories using larger instruments, varies by test.

Accession Number: PB92-227859
Price: A07

Measuring Growth in the Volume and Intensity of Medicare Physician Services: 1985-1989

This study represents a methodological innovation in the measurement of price and V/I growth. Using the 1985-89 BMAD file, growth in spending was decomposed into shares due to growth in beneficiaries, Medicare allowed prices, and V/I. This decomposition is presented by TOS, specialty, and type of geographic area.

Accession Number: PB92-227156
Price: A03

Measuring Prices of Medicare Physician Services: 1985-1988

This study develops comprehensive indexes of price change for all Medicare physician services to decompose growth in Medicare physician spending into its underlying price and V/I components. Aggregate price differences were also measured to understand geographic variation in expenditures. The first index is used to measure price changes over time and is computed for all physician services and for each type-of-service category. The second index measures cross-sectional differences in prices. The report summarizes the conceptual basis for selecting an appropriate index form, describes selecting the specific services included in the indices, and presents actual values for both forms of the index and the geographic areas of interest.

Accession Number: PB92-218502
Price: A04

Measuring Prices of Medicare Physician Services 1985-1988: Computer Product

This computer product (diskette) and documentation contains nine ASCII files of selected job outputs related to the price index output from Measuring Prices of Medicare Physician Services: 1985-1988. The documentation contains a brief description, file name and size, record count and name, variable names, and the print output from each file.

Accession Number: PB92-504299
Price: D02 computer product

Medical Assistance Facility Certification Criteria

This study provides detailed descriptive information on two proposed alternatives to rural hospitals: MAFs and RPCHs. The differences between hospitals identified under each alternative and average rural hospitals are discussed.

Accession Number: PB92-115781
Price: A04

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Medicare Hospital Outpatient Department Services: An Econometric Analysis

This report contains a descriptive analysis of hospital outpatient department costs and charges. These statistics are presented for various classes of hospitals. A multivariate regression approach is used to determine the effects of hospital characteristics on costs and charges. Both a fully specified model and a model restricted to policy-relevant characteristics are explored.

Accession Number: PB92-196211
Price: A05

Medicare Hospital Payment Policies: Impact on the Nursing Shortage

This report explores the relationship between changes in hospital reimbursement policies and the nursing shortage of the mid-1980s. It shows that involvement of RNs responded to increased demand induced, in part, by the PPS. Increased demand for RNs was associated with changing labor mix and growth in hospital output prices, not with the increased case complexity, as widely suggested in the literature.

Accession Number: PB92-172972
Price: A03

Medicare Physician Type-of-Service (TOS) Classification System: Computer Product

This is the personal computer product for the new TOS classification system developed to study physician service and expenditure growth. Using the new taxonomy, physicians classified 7,000 HCPCS codes into clinically and statistically meaningful categories. The final 23 mutually exclusive categories of the new system subdivide the current Medicare TOS classifications into fewer aggregate groups, which are more useful for analytic, policy, and program analysis.

Accession Number: PB92-501295
Price: D02 computer product

National and Cross-National Study of LTC Populations: Volume 2

This second and final report has two principal components: (1) a continuing analysis of the characteristics of the functionally impaired aged Medicare beneficiaries; and (2) a simulation of the impact of MCCA on the medical expenditures of the functionally impaired aged if the provision of the law had been in effect during the 1982-83 period. The analytic structure refinements capitalized on the longitudinal structure of the survey to permit a better handling of the timing of events and competing risks by using a multivariate event history model in which functional status was modeled as multidimensional and continually graded to ascertain the amount of "human capital" left at advanced ages. This provides an integrated model for forecasting health and functional changes in the elderly Medicare-eligible population and for determining the influence of changes in health and functioning on acute and LTC health costs. The report examines the impact of MCCA by several income and demographic characteristics.

Accession Number: PB92-188457
Price: A11

National Program to Improve the Quality of ICU Services

The primary objective of this project was to examine organizational and managerial factors associated with differences in ICU performance. Clinical and physiological data were collected on about 400 consecutive ICU patients. Using the APACHE III system, data from each patient's clinical record was reviewed for prognostic stratification. Data on hospital characteristics and organizational and managerial variables were collected. Findings show that differences in APACHE III risk-adjusted mortality were most strongly associated with differences in technological capability and diagnostic diversity: The greater the technical capability of the unit, the lower its risk-adjusted mortality, and the greater the number of different conditions

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treated in the unit, the higher its risk-adjusted mortality rate. Hospital organizational and managerial variables played a role in explaining differences in technological capability and diagnostic diversity. The organizational/managerial excellence variables were significantly associated with lower actual to predicted LOS, lower nurse turnover, technical quality of care, and staff evaluation of the ability to meet family needs.

Accession Number: PB92-121474
Price: A12

Nursing Home Bed Supply and Medicare Inpatient Utilization: 1981-86

This study investigates the substitutability of nursing home care for alternative dimensions of hospital care. The hypotheses of the study are that increases in the ratio of Medicare or Medicaid certified nursing home days to the elderly population in an area will not only reduce average LOS but will also tend to reduce the rate of hospital admissions and readmissions. While increased availability of nursing home beds was found to reduce the average LOS, it also appeared to stimulate rather than reduce hospital admissions for aged beneficiaries living in urban areas and to increase the likelihood of rehospitalization. The relation between nursing home beds and hospital use is positive, even after controlling for persistent county-specific effects.

Accession Number: PB92-196203
Price: A04

Patient Classification Systems: An Evaluation of the State-of-the Art (Volume 1)

This report evaluates eight mainstream SOI systems for use in conjunction with DRGs for hospital reimbursement, hospital management, and quality of care. The analysis is based on approximately 15,000 hospital discharges for FYs 1984-85. Also analyzed is the 1988-89 20-percent MEDPAR file, which focuses on the predictive validity and reliability of the systems as well as their impact on payment at the hospital level. All systems worked well with respect to predicting cost, outcome, and adverse outcomes.

Accession Number: PB92-123405
Price: A10

Personal Characteristics and Spells Without Health Insurance

This report uses a hazard model of spell durations to estimate the relative effects of socioeconomic and demographic characteristics on the duration of a spell without health insurance. The following variables have positive and statistically significant effects on the probability that an uninsured spell will end: monthly family income; having higher education levels; being employed in manufacturing, trade, or business and professional services sectors; continuing to work full-time after losing health insurance; and being a female. Individuals who are married or widowed/divorced/separated are likely to regain health insurance coverage more quickly than those who have never married.

Accession Number: PB92-227180
Price: A03

Pilot Study of the Adequacy of Post-Hospital Community Care for the Elderly

This study examines the development and field-testing of methods for determining appropriateness of post-discharge aftercare services. Study methods involved classifying patients at the time of their discharge from the hospital according to post-discharge service needs, and applying professionally developed guidelines to project minimal levels of aftercare requirements. Appropriateness was determined by comparing services received with these projected requirements based on interview data. Findings indicated that the data collection methods were feasible and hospital participation and interview rates were high. The validity of the aftercare guidelines was confirmed through analysis of patient adverse outcomes.

Accession Number: PB92-231273
Price: A14

Primary Care Case Management Evidence From Medicaid: Synthesizing Program Effects by Program Designs

This study examines evidence from the first decade of the post-OBRA PCCM in Medicaid. Twenty-five programs in 17 States were reviewed to develop a conceptual model linking program structure and findings. A taxonomy was applied to key design features of each

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program, collapsing them into three prototypes: Type 1—FFS primary care gatekeeper enrollment; Type 2—at-risk (capitated) primary gatekeeper enrollment; and Type 3—prepaid health plan enrollment. Findings resulting from the application of the prototype across programs are discussed.

Accession Number: PB92-129220
Price: A14

Prospective Capital Payment: Refinements and Impact Projections for Medicare Capital Expenditures

This report estimates the current and future Medicare share of PPS hospital capital expenses, and estimates the rate at which costs associated with 'old' capital (assets acquired before FFY 1989) will decrease in the future. Results are broken out by hospital characteristics such as region, urban and rural status, bed size, and ownership. The results show that for PPS5, Medicare capita expenses consisted of 57 percent depreciation, 24.5 percent moveable equipment, 33 percent interest, and 10 percent other expenses. The mean depreciable asset age was 6.9 years.

Accession Number: PB92-158393
Price: A05

Recent Trends in Length of Stay for Medicare Surgical Patients

This report presents recent trends in LOS for Medicare surgical patients. Average LOS for hospital inpatient care declined steadily for Medicare patients from the late 1960s through the early 1980s. LOS declined in 1981 by an average annual rate of 1.4 percent. From FY 1981-85, LOS declined an average of 4.7 percent. Between FY 1985-87, LOS decreased an average of 0.6 percent.

Accession Number: PB92-128522
Price: A04

Spells Without Health Insurance: The Distribution of Durations When Left-Censored Spells Are Included

This study estimates relative effects of socioeconomic and demographic characteristics on the duration of a spell without health insurance. The distribution of durations of spells without health insurance provides further evidence that the uninsured population is heterogeneous. Further research is needed to determine if there is sufficient observed and measured heterogeneity in the population to distinguish people who are likely to have long versus short spells.

Accession Number: PB92-227230
Price: A03

A Study of Coding Accuracy in Outpatient Care Facilities

This study determines the process for coding diagnosis and procedures on Medicare outpatient facility bills. A non-scientific sample of codes, supervisors, and facilities was studied with regard to major qualifications, organizational position, quality of medical records, availability of coding manuals, sources of coding advice, and perceptions of sources of problems. Major problems reported included: inconsistency and timeliness of coding advice; acceptability of codes by payers; establishment of uniform coding standards; coding from incomplete documentation and lack of a central authority for coding information.

Accession Number: PB92-196146
Price: A04

Suitability of Grade-of-Membership Techniques to Correct for Selection Bias in the Social/ Health Maintenance Organization Evaluation

This study assesses the suitability of GoM analysis to correct for selection bias in the S/HMO demonstration. GoM is discussed in the context of data reduction techniques. The researchers conclude that GoM does not correct for selection bias or bias based on unobserved variables. Comparison of different GoM specifications can inform one as to the presence of selection bias. The researchers suggest testing for the presence of selection bias by estimation of selection-corrected outcome equations.

Accession Number: PB92-185552
Price: A03

Suitability of Non-Random Designs for PACE Evaluation

This study assesses the suitability of using a selectivity bias model to correct for selection bias due to non-random assignment in the PACE demonstration evaluation. Provided are a

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discussion of selectivity bias models in general, arguments against randomization, discussion of the varieties of selection, a review of selection issues in the PACE evaluation, and a discussion of non-selection issues to be faced in the PACE evaluation. The researchers conclude that use of a selectivity bias model is an appropriate methodology for addressing selection bias in the evaluation, given the availability of instruments that can be used to identify the outcome equations.

Accession Number: PB92-185560
Price: A03

Summary of States' Efforts to Positively Affect the Quality of Medicaid Home and Community-Based Services for Persons With Mental Retardation and Related Conditions

This report summarizes the types of activities engaged in by States to positively affect the quality of HCBS for persons with MR/RC. In addition, it briefly describes specific innovative activities within nine States. These activities are subsumed under five broad topical areas: case management, personnel training, technical assistance, program monitoring, and information management.

Accession Number: PB92-124056
Price: A07

Surgical Global Fee Packages

Most major surgical procedures historically have been reimbursed through a global fee that covers the operation itself and predefined amount of pre- and postoperative care. With uniform global fee definition, HCFA might want to factor in RVUs for additional visits that may be billed separately and subtract RVUs for visits that no longer will be permitted under the standardized fee definition.

Accession Number: PB92-139062
Price: A03

Technical Support for the Medicare Fee Schedule Notice of Proposed Rule Making

This report is comprised of the responses made by HCFA to the 95,000 responses received pertaining to the proposed rule on MFS RVUs.

Accession Number: PB92-179449
Price: A19

Time Trends in Inpatient Physician Spending

This report seeks to better understand inpatient physician spending which grew at an annual rate of 6.3 percent from 1985-89. Medicare spending increased 36 percent per episode in just 4 years. There was considerable variation in expenditure growth across DRGs ranging from 11 percent to 61 percent, with surgical DRGs experiencing larger rates of growth than medical DRGs.

Accession Number: PB92-179431
Price: A07

Urban and Rural Physicians: Considerations for Medicare Payment Reform

In this report, differences between urban and rural physicians are examined for Medicare physician payment reform implications. The physician characteristics studied include: specialty, board certification, solo practice, utilization, fees, expenses, income, Medicare participation and assignment, and sources of revenue. Consistent with other research, urban physicians are more specialized than rural physicians. Analysis of utilization indicates that rural physicians have higher Medicare patient volumes and balance bill more than urban physicians. Because of the differences, Medicare physician reform may have a mixed effect on rural physicians.

Accession Number: PB92-227222
Price: A04

See the NTIS Price Schedule on page 83 for current publication prices.
All prices listed are for paper copy unless otherwise indicated.

Use of Market Force Dynamics to Set Medicare Fee Schedules

This study examines the potential for using market force dynamics to set MFSs that approximate the prices that would be charged in a competitive market. In particular, the researchers focused on the potential for using competitive bidding to set MFSs for clinical laboratory tests. Part of the study was to review a previous Medicare demonstration project that was designed to evaluate competitive bidding for clinical laboratory services. The researchers examine the proposed bidding process, analyze probable bidding strategies for providers, and assess whether the design was still appropriate in light of changes in the industry since the demonstration was proposed.

Accession Number: PB92-222504
Price: A10

Use of New Patient Codes by Medicare Physicians

This study provides a descriptive analysis of the current use of new patient visit codes. Average allowed charges and prevailing charges for new and established patient codes for the different levels of service are compared.

Accession Number: PB92-128412
Price: A05

See the NTIS Price Schedule on page 83 for current publication prices.
All prices listed are for paper copy unless otherwise indicated.

Aging Network: Strengthening the Linkages Between Hospitals, Community Health Centers, and Social Services

This report describes a number of aging community and health network demonstration projects in terms of the problems each program addressed, the organizational structure of the programs developed in each locality, evaluation issues addressed by each program, data on clients served, and conclusions reached in each program. Finally, a conclusion section delineates the lessons learned by each program and makes suggestions for organizations wishing to replicate these programs in their own areas.

Accession Number: PB91-227629
Price: A05

Analysis of Employer-Sponsored Retiree Health Insurance

This study examines employer-sponsored retiree health insurance held by the Medicare elderly. The report examines the extent to which employers now provide health insurance as a post-retirement benefit; provides a detailed description of the content of this coverage, including how employers coordinate it with Medicare; assesses how retiree coverage alters the "total health insurance" of a dually covered beneficiary; determines why employers provide retiree health insurance; describes the prevalence of all forms of supplemental health insurance among the elderly; and assesses the total health insurance of Medicare beneficiaries based on available knowledge of the benefits within different types of supplements and the prevalence of each.

Accession Number: PB91-151779
Price: A06

Analysis of Group-Specific Medicare Volume Performance Standards

This study examines the potential for separate VPS for qualified physician volunteer organizations whose experience would be measured directly, rather than based upon the experience of the national Medicare VPS specified by OBRA 1989. Empirical analyses of FFS provider characteristics and utilization patterns were conducted to explore models in which volume performance was based upon historical V/I rates for a volunteering organization. Four models considered for implementing VPS are: (1) enrolled programs such as HMOs, PROs, and HCPPS (enrollment model); (2) large multispecialty groups that manage a wide range of services for their patients (patient management model); (3) other practices with high levels of reimbursement that could manage their own services (practice management model); and (4) a combination of practices voluntarily grouped (pooling model).

Accession Number: PB91-236034
Price: A07

Analysis of Long-Run Rate Setting Strategies for Risk-Based Contracting Under Medicare

This report consists of five papers relating to the AAPCC: (1) A review of the literature through 1987 on ratesetting for HMOs; (2) a method to adjust the AAPCC which would blunt the impact of any biased selection into HMOs; (3) a proposal for and analysis of a move from county rates to larger area, urban, and rural rates; (4) the development of a model for analyzing the relationship between broad market characteristics and Medicare costs; and (5) a simultaneous equations analysis of HMO impacts on the AAPCC and vice versa.

Accession Number: PB91-117366
Price: A10

Analysis of Long-Term Care Payment Systems Final Report: Executive Summary

This study analyzes three major payment systems for Medicaid nursing home care: case-mix, facility-specific, and class-rate systems. The study incorporated major primary and secondary data collection and analysis activities, as well as site visits and case studies. The major analyses are reported in three volumes.

Accession Number: PB91-160507
Price: A03

See the NTIS Price Schedule on page 83 for current publication prices.
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Analysis of Long-Term Care Payment Systems (Volume 1, Final Report): A Multi-State Analysis of Medicaid Nursing Home Payment Systems

This report analyzed three major payment systems for Medicaid nursing home care in seven States. Analyses of differences among the three payment system types in terms of case mix, quality, cost per day, Medicaid payment rate per day, and profitability were conducted. The study found that case mix was more intense in case-mix States compared with class-rate States, with facility-specific States in between. Although facility-level analyses did not find major quality differences among payment systems, the patient-level analyses implied for most variables either the same or higher quality in case-mix States compared with other States. Also, case studies found indications of improved quality in several States after the implementation of case-mix systems.

Accession Number: PB91-160515
Price: A13

Analysis of Long-Term Care Payment Systems (Volume 2, Final Report): Administering Nursing Home Case-Mix Reimbursement Systems—Issues of Assessment, Quality, Access, Equity, and Cost

This report presents the results of studies conducted in 1987 on the six States with case-mix systems then in operation: Illinois, West Virginia, Ohio, Maryland, Minnesota, and New York. The case studies examined resident assessment systems, quality of care, access to care, and cost containment and equity. The case studies found no systematic actions to allow deterioration of patients because of the financial incentives under a case-mix system. All States had developed mechanisms to counteract such potential incentives and, in addition, the data base generated by the case-mix systems facilitated quality assurance efforts. Most States found improved access to be an important positive outcome of adopting a case-mix system. Cost containment results varied among the States.

Accession Number: PB91-160523
Price: A06

Analysis of Long-Term Care Payment Systems (Volume 3, Final Report): Analyzing Nursing Home Capital Reimbursement Systems

This report analyzes alternative Medicaid payment methodologies for nursing home capital. The analyses used a simulation model, with information from the study States to compare and contrast the traditional and two fair rental capital payment approaches. The model enabled the comparison of alternative capital payment systems over time periods up to 30 years. The three financial outcome variables examined were cash flow, cost to the State, and rate of return to investors. The report concludes that the fair rental approaches offset the incentives of the traditional system for nursing home owners to frequently sell or refinance facilities. The results of the simulation model analyses suggested that these advantages could be obtained without greatly increased costs to the States over time, either for rate payments or for administration.

Accession Number: PB91-160531
Price: A05

Assessing the Impact of Changes in Technology on Medicare Expenditures for Physician Services: Background, Issues, and Options

This report addresses the following: (1) conceptual and terminological issues, (2) approaches used to analyze the impact of technological change on health expenditures, and (3) major alternative approaches for assessing the impact of technological change on Medicare expenditures for physician services. Two general methods for measuring the impact of technology on costs were identified and are discussed in the final report. These include: (a) the residual approach, and (b) the technology-specific approach. The report suggests that MVPS refinements based on technology changes are not desirable because of difficulties in measuring costs implications of emerging technologies, and the appropriateness of using a global type reimbursement control mechanism to affect technology-specific diffusion.

Accession Number: PB91-227413
Price: A03

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Assessment of the Physician Payment Review Commission's Proposed Geographic Areas for the Medicare Fee Schedule

This analysis compares the PPRC's proposal to reconfigure payment localities under the MFS to two options developed by the Urban Institute. The authors conclude that the PPRC proposal may be stronger in reflecting the measured differences in input prices incorporated in the GPCI among MSAs but that the Urban Institute options more closely approximate within-MSA input differences by recognizing an urban core. The major tradeoffs are simplicity versus recognition of measured input price variation and the extent to which rural areas versus suburban rings gain or lose.

Accession Number: PB91-200766
Price: A03

Blue Cross and Blue Shield of Arizona Medicare Physicians PPO Demonstration Status Report

This report describes the Medigap PPO developed by BCBS/AZ and its early operational experience. This description includes an overview of BCBS/AZ and its market area, its history, its experience with the PPO concept in the private sector, and its reasons for developing a Medigap PPO. This report examines the following topics: (1) design of the benefit package; (2) marketing approaches; (3) the criteria and process for selecting network providers; (4) utilization management procedures; and (5) quality assurance procedures.

Accession Number: PB91-106906
Price: A06

Bundling Outpatient Hospital Physician Services: Results and Implications

This study describes Medicare physician services provided at hospital outpatient departments and explores implications for bundling selected services during a single visit and over time. Patterns of outpatient physician services are examined by Medicare eligibility class—for aged, disabled, and ESRD beneficiaries, and by reason of visit. Certain routine services provided to most users regardless of visits could be considered for inclusion for a bundled payment to physicians for the outpatient visit. Finally, the small number of different physicians seen by the aged and disabled suggest that the feasibility of capitation on a broader basis should be explored.

Accession Number: PB91-241299
Price: A03

Capitation Rates for the Frail Elderly

This report uses data gathered as part of the S/HMO demonstration to develop a model to predict whether a person is NHC. The data include a health status form completed by each S/HMO member and data from a clinical assessment of persons who were regarded as requiring LTC services. Per capita costs of the MNHC sample for the period 1982-84 were then estimated. The best estimate is that per capita Medicare costs of the frail elderly who are NHC average 2.42 times higher than the average per capita costs for the overall elderly population.

Accession Number: PB91-141408
Price: A05

Causes of Failure to Transplant Cadaveric Human Organs

This study examines the level of harvested kidney loss and the reasons for those losses. Data were collected on 3,503 kidneys, of which 181 were discarded, a loss rate of 5.2 percent. The major reasons for discard were donor or organ pathology (29 percent), anatomic abnormalities (17 percent), surgical complications (11 percent), positive cultures (11 percent), and organ injury prior to nephrectomy (9 percent). Despite room for some improvement, some kidney wastage an inevitable result of an aggressive organ procurement policy.

Accession Number: PB91-158386
Price: A05

Changes in Hospitals' Charges to Privately Insured Patients During PPS

This study attempts to determine whether hospitals that face relatively greater fiscal pressure from PPS increase their charges to privately insured patients more than hospitals under relatively lesser PPS fiscal pressure. The results suggest that either there is no relationship between hospitals increasing charges to private third-party payers and low profits or

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losses from PPS, or charges to private third-party payers increase more when profits are high.

Accession Number: PB91-136010
Price: A03

Correlates of Incontinence: An Analysis of Nursing Home Data From the Medicare and Medicaid Automated Certification System

This study examines some of the correlates of incontinence and toileting of nursing home patients residing in Medicare and Medicaid-certified nursing homes. It is a facility-level analysis designed to examine the relationship among the percentages of patients who are incontinent, the percentage not toileted or needing assistance in toileting, and other facility or resident characteristics of nursing homes. Study findings indicate that incontinence is a problem of major proportions in all sizes and types of nursing homes, affecting approximately two-thirds of all residents. Furthermore, the treatment patterns, in terms of toileting as well as the use of catheters, varied across different types of facilities.

Accession Number: PB91-241703
Price: A04

Design and Evaluation of a Prospective Payment System for Ambulatory Care

This study applies and tests the basic concepts of the inpatient PPS in the outpatient setting. The objective is to develop a payment system design that provides the basic structure for an outpatient PPS, but is flexible enough to accommodate a wide range of policy options.

Accession Number: PB91-160754
Price: A16

Determinants of Total Family Charges for Health Care: United States, 1980

This report addresses the question "What are the determinants of the total charges for health care that U.S. families face." The determinants of total charges and their importance are identified principally through multiple regression analysis. Total charges are defined as the full amount charged for all types of health care for all family members regardless of whether these amounts are paid out of pocket, paid by insurance (or public health care coverage programs), or go unpaid. The data used are from the family data files of the 1980 NMCUES.

Accession Number: PB91-122705
Price: A04

Developing and Evaluating Options for Pediatric Prospective Payment Systems

This study evaluates PM-DRGs and addresses payment options for pediatric and neonatal patients. The major findings include: (1) PM-DRGs perform better than the DRGs in explaining variations in resource use. (2) Grouping patient data using PM-DRGs does not result in a significant increase in the number of groups with a small number of discharges. (3) Using PM-DRGs instead of DRGs would not result in substantial changes across all hospitals in revenues. (4) Children's hospitals are so diverse with respect to bed size, specialization, and level of teaching intensity that it may be difficult to treat them as a single class of hospital in a payment system.

Accession Number: PB91-171140
Price: A13

DME Competitive Bidding Demonstration: Case Studies of OBRA's Effect on Access to DME

This report examines whether OBRA 1987 changes in Medicare's reimbursement policies had any effect, especially any restrictive effect, on beneficiaries' access to needed DME. Results were essentially the same for both urban and rural areas—the new fee schedule methodology seemed to have little effect on DME availability. Home oxygen systems were noted as a possible exception. Thus the profile of the three different oxygen delivery systems has changed. The report states the change may have been caused by other HCFA administrative directives tightening the coverage requirements for home oxygen rather than by the new payment schedule.

Accession Number: PB91-193490
Price: A03

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DME Competitive Bidding Demonstration: Final Report—Options for Medicare Reimbursement of Durable Medical Equipment

This report summarizes 5 years of work by Abt Associates, Inc. examining Medicare reimbursement policy and future directions. In all, 11 reports were produced—the first 6 concerning the planning for the competitive bidding demonstration and the final 5 directed at examining the impact of the OBRA rules and future reimbursement options.

Accession Number: PB91-193466
Price: $19.50 paper copy

DME Competitive Bidding Demonstration: Review of Reimbursement Methods of Other Payers for Durable Medical Equipment

This report focuses on three competitive bidding programs for DME in major public programs; specifically, the acquisition of home oxygen services by VA, the acquisition of home oxygen services by the Medicaid program in Utah, and same services plus wheelchair acquisition by the Minnesota Medicaid program. The report explains how competitive bidding is handled, cost savings of competitive bidding as compared with Medicare reimbursement, how quality is monitored, and finally, if any procedures have operational feasibility for the Medicare program.

Accession Number: PB91-193482
Price: A05

DME Competitive Bidding Demonstration: Simulation of the Impact of OBRA 1987 on Reimbursement of Durable Medical Equipment

This report presents an analysis of the effect of OBRA 1987 on Medicare total allowed charges for DME during 1989. Using assumptions regarding inflation rates and changes in supplier billing, schedule still reflected widely varying rates for the same or similar items in different carrier jurisdictions. Overall, the analysis indicates that unless suppliers react to published fee schedule amounts and begin billing at those limits, the OBRA 1987 changes have little impact on Medicare spending for DME.

Accession Number: PB91-193474
Price: A07

DME Competitive Bidding Demonstration Working Paper: Methodology for Constructing the Simulation Model Database (Volumes I and II)

This report describes the DME data sources used to create a model for simulating the effect of OBRA 1987 fee schedules vis-a-vis what Medicare would have reimbursed following former reasonable charge methodologies. OBRA 1987 grouped DME into six categories with varying reimbursement fee schedules designated for each, and established rules regarding rental or purchase and timeframes.

Volume I
Accession Number: PB91-193532
Price: A08

Volume II
Accession Number: PB91-193540
Price: A14

Drug Utilization Review in the Private Sector

This study evaluates the major DUR programs in the private sector. All of the surveyed programs were found to rely heavily upon data generated by prescription drug claims processing systems. Most interventions were targeted at dispensing rather than prescribing practices. This study developed a typology of five levels of review activity to classify programs according to the focus and intensity of their efforts. Various cost functions were also estimated. Overall, the evidence suggests that reduction in drug costs to the insurer exceeds the costs of DUR at any of the five levels. The authors recommend a PPS as offering the greatest potential for improvement in the quality of drug therapy while reducing costs.

Accession Number: PB91-172320
Price: A06

See the NTIS Price Schedule on page 83 for current publication prices.
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Economies of Scope and Payment for Medicare Physician Services

This study addresses the issue of economies of scope in the production of physician services. Economies of scope exist when the amount of work required for joint outputs is less than the sum of work required to produce each service independently. Based upon a pilot survey using six vignettes depicting clinical situations familiar to internists, it is determined that economies of scope can and do exist in the production of physician services.

Accession Number: PB91-173872
Price: A06

Empirical Analysis of Alternative Geographic Configurations for Basing Medicare Payments to HMOs

County-based HMO payment rates have been criticized in light of substantial variations in rates among neighboring countries and large fluctuations in rates over time. The report evaluates nine alternative configurations and the county on the basis of payment area homogeneity, payment rate stability, and policy criteria. The empirical results reveal rather modest differences among most alternative configurations on measurable performance indicators and do not lend strong support for payment area reconfiguration at this time.

Accession Number: PB91-113092
Price: A03

End Stage Renal Disease: 1988 Research Report

The report reflects a wide range of data and analyses regarding the Medicare ESRD program. The report emphasizes trends and comparisons over time and examines the patterns of treatment for ESRD patients. Major subject areas of the report include: incidence and enrollment; patient treatment trends; survival analyses; utilization program expenditures; providers of renal care; and abstracts of ESRD studies.

Accession Number: PB91-116681
Price: A04

Evaluation of the Geriatric Continence Research Project: Final Report

The Geriatric Continence Evaluation Project assessed the cost-effectiveness of behavioral treatment methods designed to reduce incontinence among nursing home patients. This report discusses implications of the project for reimbursement and regulation of nursing home care. The evaluation's quantitative component was a cost-effectiveness analysis of the project's behavioral methods of continence training. There was no evidence that the project was cost-effective in terms of direct costs. Although the project's treatment effect was statistically significant, the effect was too small to generate a benefit large enough to offset the additional costs of treatment.

Accession Number: PB91-241695
Price: $27.00 paper copy

Examination of the Relationship Between Medicare Prospective Payment and the Nurse Shortage, Subtitles: Background Paper for Task Order I: Final Report

This study analyzes the impact of PPS on the shortage of RNs reported in 1987. The national rate of growth of FTE RNs decreased after implementation of PPS. If the reported trends continued beyond 1985, PPS was one of the factors leading to the reported nurse shortage by increasing the demand for RNs. However, it was neither the sole nor the predominant cause of the increased demand for RNs.

Accession Number: PB91-104760
Price: A12

Future Research on the Quality of Long-Term Care Services in Community-Based and Custodial Settings: Module 1

This *Module 1 Final Report* reviews past and current research and provides recommendations for future research in the quality of community-based and custodial LTC services. This report covers a wide range of community-based services. The taxonomy used includes four main groupings: (1) assessment, information, and referral services; (2) health and support services (emphasizing primarily non-medical support

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services); (3) living arrangements; and (4) integrated systems (which combine financing and care delivery). The report discusses approaches to measuring quality as well as QA programs.

Accession Number: PB91-242198
Price: A05

Future Research on the Relationship Between Long-Term Care Services and Reduced Acute Care Expenditures: Module 2

This *Module 2 Final Report* reviews how the provision of LTC services may reduce expenditures for acute health care services. The major objective is to develop recommendations for future research to clarify the relationship between LTC services and acute-care expenditures. The scope includes LTC services and three major service categories: (1) community-based services; (2) living arrangements; and (3) alternative control/delivery/payment models (integrated systems).

Accession Number: PB91-138107
Price: A08

Geographic Medicare Economic Index: Alternative Approaches Support Documentation

This supplement contains a number of GMEI configurations different from those in the original report. One set of tables presents overhead indices for MSAs, localities, and States. The second set of tables presents detailed results for Puerto Rico. A third set of tables present the indices in a format that is consistent with the MFS for payment of Part B physician services.

Accession Number: PB91-113506
Price: A03

Geographic Medicare Economic Index (Supplement) (for Microcomputers)

The supplement contains a number of GMEI configurations different than those in the original report. One set of tables presents overhead indices for MSAs, localities and States. Other tables present detailed results for Puerto Rico. A third set of tables present the indices in a format that is consistent with the MFS for payment of Part B physician services under Medicare.

Accession Number: PB91-507426
Price: D02 computer product

Geographic Payment Areas for the Medicare Fee Schedule: Alternative Approaches

This study is a sensitivity analysis of alternatives to the 240 current Medicare pricing localities (status quo) or statewide geographic areas for possible use in the MFS. It considers the subdivision of States to recognize differences in costs of practice in large metropolitan areas. Also, the use of density to distinguish very rural areas is examined. In addition to the differences in cost of practice across areas, options are evaluated in terms of minimization of boundaries and conceptual and administrative simplicity. The CMSA option is discussed.

Accession Number: PB91-201046
Price: A06

Global Fees for Surgery

This report documents the extent to which primary surgeons and other physicians do or do not bill Medicare for pre- and postoperative care above the global fee amount for selected surgical procedures. Billings for preoperative outpatient visits are not relatively frequent for general surgical procedures and TURPS. The number of postoperative hospital visits billed in excess of the global fee is surprisingly high.

Accession Number: PB91-113498
Price: A05

Growth in Medicare Physician Services by Specialty: Implications for Volume Performance Standards

This study examines growth in Medicare physician services and allowed charges for 18 Medicare specialties for CYs 1985-88, identifies the types of services that each specialty provides, and examines changes in services and allowed charges for each specialty over time. The specialties examined are: general/family practice; internal medicine; cardiology/gastroenterology;

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psychiatry; other medical specialties; general surgery; ophthalmology; orthopedics; thoracic surgery; urology; dermatology; other surgical specialties; multi-specialty clinics; radiology; pathology and laboratory; and non-physicians. Detailed tables provide information on individual services that accounted for at least 15 percent of all Medicare allowed charges for the specialty between 1985-88, by CPT-4 or HCPCS code.

Accession Number: PB91-193730
Price: A04

Health Care Services for Children Under Medicaid

This study converts PMMIS Eligibility and Payment files to formats compatible with INFORM. Calculation of eligibility variables and creation of fixed field records allowed rapid tabulation and analyses of 18 months of children's Medicaid data for the State of Maryland. Descriptive data were assembled and certain suppositions about services and recipients were tested. Extended periods of eligibility appeared to result in a reduced need for health care services. A significant reduction in inpatient care was observed in the extended care group. Continuity of care provided by private physicians in their office practices or in a title V C&Y Project appear to assure comprehensive care at reasonable cost for certain children enrolled in Medicaid.

Accession Number: PB91-242289
Price: A12

HMO Market Share and Its Effect on Local Medicare Costs

This report uses regression analysis to examine whether HMO market share increases or decreases FFS costs. Four mechanisms by which HMOs could affect current Medicare costs are: (1) biased selection; (2) competition; (3) spillover practice patterns from IPAs; and (4) by formula. The results suggest that HMOs decrease Medicare expenditures by 1.2 percent in the short run and by as much as 3.9 percent in the long run.

Accession Number: PB91-173302
Price: A03

Hospital Data by Geographic Area for Aged Medicare Beneficiaries Selected Diagnostic Groups, 1986 (DIAGS: Volume 1, Segments 1-4) and (PROCS: Volume 2, Segments 1-3)

These reports are documentation for the data base on hospitalization rates for aged Medicare beneficiaries by MSAs and urban and rural areas within States for 14 common procedures.

DIAGS: Volume 1
Accession Number: PB91-175935
Price: A03

PROCS: Volume 2
Accession Number: PB91-175943
Price: A03

Hospital Provision of Uncompensated Care: A Data Update

This report provides a descriptive analysis of uncompensated care and hospital finances as derived from the 1987 AHA Annual Survey. In addition, estimates of the uninsured population are derived from the 1987 CPS. In 1987, there were about 37 million persons without health insurance coverage. Uncompensated care representing the total amount of free care and bad debt occurring in hospitals was estimated to be $12.6 billion.

Accession Number: PB91-113480
Price: A03

Impacts of Lagged Profits and Current Medicare Fiscal Pressure on Hospitals Under PPS

This report provides information about the adequacy of Medicare payments regarding both access to and quality of hospital care. It analyzes hospitals' actual total profit margin in 1984 and the fiscal pressure it faced from the Medicare PPS in 1985. Medicare fiscal pressure is measured by an index of the overall profit or loss a hospital might anticipate from treating a Medicare inpatient if it makes no changes in either the cost of providing care, the volume of Medicare cases, or its total expenses. The data for this analysis are from the AHA Annual Survey of Hospitals for 1983, 1984 and 1985.

Accession Number: PB91-136028
Price: A03

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Impact of Medicare's Prospective Payment System on Inpatient Care

This study analyzes the effects of PPS on the quality of hospital care, as measured by standard utilization indicators such as average LOS, and outcome measures such as discharge location, death rates (case-mix adjusted), and readmission rates. Non-Medicare discharges are used as a comparison group. The report concludes that, despite the economic incentives introduced by PPS, hospitals and practitioners responded by continuing to maintain a level of quality provided prior to the introduction of PPS.

Accession Number: PB91-200980
Price: A10

Impact of Medicare's Prospective Payment System and Private Sector Initiatives—Blue Cross and Blue Shield Plan Experience, 1980-87

The study analyzes the impact of PPS on utilization and payment for inpatient and outpatient hospital services covered by BC/BS Plans. It examines the effects of cost control efforts undertaken by the Plans, in particular the development of HMOs and PPOs. The study found that PPS was negatively related to BC/BS hospital admissions per member and payments per member. However, PPS was positively related to average LOS. BC/BS cost control efforts are also associated with reduced inpatient payment per member. The study analyzed the growth of HMOs and PPOs.

Accession Number: PB91-106898
Price: A14

Impacts of the Profit Incentive and Fiscal Pressure in the Prospective Payment System on Hospitals: Second Year Project

This report analyzes how variation in the fiscal pressure PPS imposed on hospitals affected their expenditures and other aspects of their behavior. The analysis examined: 1984-85 annual percent changes in Medicare LOS, discharges, and outpatient visits; non-Medicare LOS, discharges, and outpatient visits; the 1984-85 absolute change in hospitals' total financial margin as a percentage of total revenues, and percentage changes in total expenses, non-payroll expense per discharge, average salary per nurse, and average salary per non-nurse employee; total beds and staffing; inpatient and ambulatory surgical operations; and the absolute change in the percentage of hospitals offering home health or LTC.

Accession Number: PB91-136002
Price: A04

Long-Term Care of Aged Hip Fractures: Public Versus Private Costs

This report examines the complex economic and psychosocial determinants of the public and private contribution to the LTC of a group of aged individuals who suddenly became disabled by hip fractures. The impact of multiple demographic and socioeconomic factors were analyzed in terms of the decision to enter a nursing home or return home. Study data came from 858 patients from seven hospitals in the Baltimore, Maryland area.

Accession Number: PB91-168609
Price: A20

Manufacturers' Prices and Pharmacists' Charges for Prescription Drugs Used By the Elderly

This report focuses on those drug entities that account for a significant proportion (80 percent) of the elderly's retail expenditures on prescription drugs. The report also analyzes changes in manufacturers' prices and pharmacists' charges for those drugs from 1981-88.

Accession Number: PB91-100255
Price: A07

Maryland Program for Prepaid Managed Health Care

This report assists in the establishment of new approaches to prepaid medical plans for medical assistance recipients that would reduce Medicaid expenditures while assuring access to quality health care.

Accession Number: PB91-111716
Price: A04

Medicare Cost of Training for Self-Care Dialysis: An Estimation by Statistical Cost Function

This report focuses on Medicare cost finding for dialysis care by using regression techniques for estimating statistical cost functions based on

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simple measures of bottom line costs and the multiproducts of dialysis units. It compares the results of the estimated cost functions with the more traditional approach of using accounting weighted estimates. The multi-product outputs in-center hemodialysis, home hemodialysis, and CAPD treatments, training of self-care hemodialysis patients, and training of CAPD patients.

Accession Number: PB91-171058
Price: A03

Medicare Hospital Outpatient Department Services: Descriptive Analysis

This report provides information relevant to the design and implementation of payment reform in hospital outpatient departments. The document contains data on the patterns of beneficiary visits, the most frequently performed procedures, specific procedures, and the types of services accounting for the most expenditures. In addition, there is information comparing average charges, cost, outliers, and case mix, by hospital type.

Accession Number: PB91-161190
Price: A06

Medicare Therapeutic Shoe Demonstration

OBRA 1987 mandated a demonstration to test the cost-effectiveness of providing therapeutic shoes to Medicare beneficiaries with severe diabetic foot disease. This final report to Congress is unable to show that the benefit was not cost-effective. The report indicates that since there is insufficient data to evaluate the cost-effectiveness of the therapeutic shoe benefit, the demonstration will continue for 2 additional years until October 1992.

Accession Number: PB91-113118
Price: A05

Medicare Volume Performance Standard Rates of Increase for Physician Services Differentiated by Geographic Area, Specialty, or Group of Specialties, and Type of Service

OBRA 1989 required a study of the feasibility of establishing separate Medicare VPS rates of increase for physician services differentiated by geographic area, specialty or group of specialties, and type of service. The report summarizes the progress HCFA has made and describes the directions to be taken in the future.

Accession Number: PB91-158329
Price: A02

National Study of Resource-Based Relative Value Scales for Physician Services: Phase 2 Volume 1: Executive Summary

This executive summary includes descriptions of the methodological changes that were made in the second phase and a brief description of the results. Among these changes are: more collection of primary data on pre- and postwork for evaluation and management services; two-step estimation for linking; and refinement of the extrapolation methodology.

Accession Number: PB91-172189
Price: A03

National Study of Resource-Based Relative Value Scales for Physician Services: Phase 2 Volume 2: Final Report

This study generated relative values for approximately 2,700 codes, representing 95 percent of Medicare-allowed payments. The report includes methodology used in the study, and results and analysis for all surveyed vignettes. It also includes relative work values for all CPT-4 codes that were included in both phases of the study, with several exclusions.

Accession Number: PB91-172197
Price: A99

National Study of Resource-Based Relative Value Scales for Physician Services: Phase 2 Volume 3: Appendices

Appendices included in Volume 3 are: national survey questionnaires, cross-specialty linkages, regression methodology, and publications from the study.

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National Study of Resource-Based Relative Value Scales for Physician Services: Phase 2 Volume 4: Data Files Documentation

This computer product includes documentation for 39 data files and appendixes.

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National Study of Resource-Based Relative Value Scales for Physician Services: Phase 2 Volume 5: Data Files

Accession Number: PB91-172221
Price: A99

National Study of Resource-Based Relative Value Scales for Physician Services: Phase 2 Survey Results for Microcomputers

This is the computer product for Phase 2 of the National Study of Resource-Based Relative Value Scales for Physician Services. The two disks contain survey information, final values and documentation.

Accession Number: PB91-507251
Price: D08 computer product

Outcomes Measures for the Assessment of Hospital Care

This report examines the value, potential, and limitations of Medicare claims data and functional status measures for evaluating the effectiveness of medical practices and the quality of care provided to Medicare recipients, as well as identifies the relevant health outcomes for breast cancer, hip fracture, and myocardial infarction. The findings indicate that claims data have great potential as a means to assess health care outcomes and contribute to the evaluation of the effectiveness of medical practices and quality of care. At present, such use of claims data should be considered investigational and preliminary.

Accession Number: PB91-227439
Price: A03

Out-of-Pocket Costs of Medicare Beneficiaries for Physician Services

This report to Congress focuses on physician participation in Medicare assignment, billing, and collection rates, and how recent legislation may affect these rates and beneficiary liabilities. It concludes that efforts in the area of Medicare beneficiary liability protection in regard to balance billing have thus far been successful in both increasing assignment and reducing billing costs. New statutory limits on balance billing will act to reduce the amount and burden of out-of-pocket liability which beneficiaries face, and although Medicare has been paying a growing share of the total costs for physician services, beneficiaries will still face rising coinsurance costs that reflect the total rise in Medicare physician expenses.

Accession Number: PB91-164202
Price: A03

Payment Amount for Capitated Systems

This report describes a new approach in which HMO payment rates are based on two factors—the input costs an HMO faces and the health status of the Medicare beneficiaries who enroll in HMOs. It proposes an outlier adjustment for beneficiaries whose expenditures exceed a threshold in a given year. It also proposes a formula for monitoring changes in health status over a multiple-year period.

Accession Number: PB91-119297
Price: A10

Predicting Post-Operative Adverse Events of Common Surgical Procedures in the Medicare Population

This report develops severity of illness models using chart-abstracted data from hospital admissions to predict adverse outcomes following four procedures: CABG, coronary angioplasty, cholecystectomy, and prostatetomy. Combinations of clinical variables indicating severity of both the index disease and comorbid conditions were strongly associated with, but only weakly predictive of, the occurrence of postoperative adverse events within each surgical procedure.

Accession Number: PB91-200592
Price: A11

Prior and Concurrent Authorization for Home Health and Skilled Nursing Facility Services

This report responds to concerns expressed by HHAs and SNFs that, under the current payment authorization system, agencies cannot

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adequately predict what services would be approved by the fiscal intermediaries before services are provided. It is hypothesized that prior authorization (PA) and concurrent authorization (CA) approaches would reduce the number of services denied without increasing Medicare expenditures. The report describes the results of the evaluation of a pilot project testing CA of home health services and proposed design of a forthcoming demonstration that will test PA/CA for SNFs.

Accession Number: PB91-120519
Price: A13

Promoting Geriatric Self-Care: Enhancing the Management of Chronic Health Problems

This report describes a project to refine a model educational program to encourage older persons to assume more responsibility for managing their health-related behavior with regard to arthritis, diabetes, and heart disease. Products developed were: Wellness Check for Older Persons, a 54-question computer-scored health risk appraisal; *Take Charge of Your Health*, a 200-page manual outlining a 9-session educational workshop series; a workshop facilitator training program; and a physician conference on self-care.

Accession Number: PB91-227579
Price: A03

Purely Data-Based Method for Long Range Forecasting of Labor Productivity

This report attempts to eliminate the judgmental aspect of long-range productivity projections made by the Medicare Trustees by taking a purely data-based, mechanistic approach based on a number of time-series autoregressive statistical diagnostics of labor productivity. Using 100 years of historical data (from 1889-89), the report finds two distinct trends in labor productivity: one from 1889 to the early 1930s and a second from the early 1930s to 1989. The report concludes that actuarial projections should be based on the entire period 1933 to present rather than the current 1950 to present. Additionally, the projections would appropriately be based on the trend in the level of labor productivity rather than on the trend in the log of labor productivity, as is now being done. These changes would result in substantially lower projected rates of growth in labor productivity in the area of 1.1 percent, rather than the current 1.7-2.0 percent, and would prevent overestimating projected revenues.

Accession Number: PB91-128454
Price: A06

Refining the Diagnostic Cost Group Model: A Proposed Modification to the AAPCC for HMO Reimbursement

This report uses a DCG regression model to improve the predictive power of the AAPCC. The researchers report that the proposed model was found to have considerably more predictive power than the AAPCC.

Accession Number: PB91-113076
Price: A07

Refining the Malpractice Geographic Practice Cost Index: Documentation

This study identifies two refinements that could improve the measurement of geographic differences in malpractice costs used to calculate the MGPCI. These refinements are associated with mandatory PCFs established in some States and with correction of several technical errors in the algorithm used to map malpractice index values to Medicare pricing localities. The revised MGPCI is considered more accurate.

Accession Number: PB91-155218
Price: A03

Refining the Malpractice Geographic Practice Cost Index: Computer Diskette, March 1991

This is the PC diskette associated with Refining the Malpractice Geographic Practice Cost Index: February 1991. The indexes for full work, quarter work, practice expense, malpractice expense, and overhead expense are provided by Medicare pricing locality, by Medicare carrier, by State, and by MSA/rural areas of States.

Accession Number: PB91-506899
Price: D02 computer product

Refining the Malpractice Geographic Practice Cost Index: 3½ Inch Diskette for Microcomputers, February 1991

This is the 3½ inch computer product associated with the study Refining the Malpractice GPCI. The indexes for full work, quarter work, practice

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expense, malpractice expense, and overhead expense are provided by Medicare pricing locality, by Medicare carrier, by State, and by MSA/rural areas of States.

Accession Number: PB91-507491
Price: D02 computer product

Report to Congress: Administratively Necessary Days

This *Report to Congress* examines whether PPS causes financial hardship for hospitals that have difficulty discharging patients because of limited access to the nursing home market. This report confirms that some hospitals incur delays in discharging patients to nursing homes. In general, discharge delays are due to: insufficient accessibility shortages; low proportions of area nursing home beds certified to provide skilled nursing care; stringency of Medicaid nursing home reimbursement, and/or areas where the marginal cost of Medicare patients is not lower than the average facility cost and the Medicare payment ceiling. The report also concludes that it is easier for hospitals to place Medicare patients in nursing homes when: nursing homes have a high proportion of private pay patients; Medicaid reimburses nursing homes on a retrospective cost basis, and nursing homes' average costs are approximately equal to Medicare's payment ceiling.

Accession Number: PB91-115469
Price: A04

Report to Congress: High Volume and High Payment Procedures in the Medicaid Program

This *Report to Congress* provides information pertaining to second surgical opinion and preadmission review in Medicaid. Three major areas are: (1) to obtain information such as payment rates, aggregate payments, and rates of performance for high-volume and high-cost surgical procedures in the Medicaid population; (2) to obtain information on the extent to which second surgical opinions or preadmission review programs may impede access to necessary care, and the measures States have taken to address such impediments; and (3) to identify surgical procedures that may be appropriate for a mandatory second surgical opinion program, considering factors about the procedures such as potential risk, volume, cost, non-confirmation rates, and geographic variation.

Accession Number: PB91-113217
Price: A09

Report to Congress: Impact of the Medicare Hospital Prospective Payment System: 1987 Annual Report

The two objectives of this *Report to Congress* are: (1) to provide an update on the status of PPS as of 1987; and (2) to report on studies of PPS impact that have been completed since the third report was prepared. Among the major findings are: Medicare benefit payments for inpatient hospital care increased by 3.7 percent in FY 1987, the smallest increase in the history of the Medicare program; and total days of inpatient care per 1,000 Medicare aged beneficiaries continued to decline in 1986.

Accession Number: PB91-121525
Price: A07

Report to Congress: Rural Secondary Specialty Demonstration Project

This *Report to Congress* describes the effect that a modified system of making payments under Part A to rural secondary specialty center would have on: (1) total expenditures under such part; and (2) the access of Medicare beneficiaries located in rural areas to quality health care.

Accession Number: PB91-119560
Price: A03

Research Issues in the Medicare Outpatient Prescription Drug Program

This report combines three separately identifiable papers on research issues in the MCAA of 1988: therapeutic drug use review; prescription drug utilization and pharmacoepidemiology; and expenditures, pricing, and finance. In addition, the report contains a series of table shells for beneficiary drug utilization and expenditure reports. The economics section contains its own set of table shells.

Accession Number: PB91-130047
Price: A07

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Resident Assessment System for Long-Term Care Facilities

This report documents a resident assessment instrument for LTC facilities. The instrument consists of the MDS, definitions, utilization guidelines, and 18 RAPs. These RAPs are problem-oriented guides that facility staff will use for further assessment when the MDS indicates a potential resident problem.

Accession Number: PB91-100263
Price: A07

Selected Analyses of PPS's Impact on Hospital Behavior

This study analyzes the impact of PPS on hospitals' expenses, Medicare volume, profit margins, input use, and charges to privately insured patients. The analyses covered the years 1982-87. Among the principal findings are: PPS fiscal pressure constrained cost growth and reduced Medicare LOS more than other hospitals; PPS appeared to provide hospitals with an incentive to shift the care of less complex patients from the inpatient to the outpatient setting and to use outpatient visits as a substitute for extra days of care for longer stay patients; and no evidence that hospitals' total charges to privately insured patients were higher in hospitals that experienced low profits, whether from PPS or from other payers.

Accession Number: PB91-135996
Price: A04

Should Ancillary Services Be Bundled Into Payments for Outpatient Surgery?

This report addresses the issue of whether related ancillary services should be included in payments for outpatient surgery. The authors conclude that bundling is recommended to help control volume and costs, particularly when used with a visit-based system.

Accession Number: PB91-168724
Price: A04

Simultaneous Equations Model of the Impact of PPS on Hospitals

This study estimates a simultaneous equation model that has as jointly dependent variables annual percentage changes in Medicare admissions, LOS, outpatient visits, case-mix index, and total hospital expenses. Interactions between PPS fiscal pressure and interhospital competition are analyzed. Researchers find that PPS fiscal pressure had a direct impact on the independent variables, and that this effect is largest in areas with 10 or more competing hospitals. Hospital competition appears to have relatively little impact. Evidence of substitution between inpatient and outpatient care, and among hospital, physician, and nursing home care is found.

Accession Number: PB91-136044
Price: A03

State Survey of Community-Based Care Systems: Summary of Quality Assurance Mechanisms in Sixteen States: Module 1

This *Module 1 Report* gathers information on the development of 16 States' community-based LTC programs. Problems are reviewed in order to derive helpful criteria for other States as they develop similar care delivery systems.

Accession Number: PB91-141416
Price: A07

Survey Procedures and Interpretive Guidelines for Laboratories and Laboratory Services: Appendix C

This report provides guidance to State surveyors for conducting inspections for determining laboratory compliance with revised regulations for Medicare/CLIA programs. The definition of a 'laboratory' means a facility for the biological, microbiological, serological, chemical, immunohematological, hematological, biophysical, cytological, pathological, or other examination of materials derived from the human body for the purpose of providing information for the diagnosis, prevention, or treatment of any disease or impairment of, or the assessment of the health of, human beings.

Accession Number: PB91-167684
Price: A12

Using a New Type-of-Service Classification System to Examine the Growth in Medicare Physician Expenditures, 1985-1988

This report describes the development of a new physician TOS classification system that subdivides Medicare categories of services into fewer

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aggregate groupings than the current system. The primary objectives of this study were to allow better discrimination among services and to minimize the use of residual categories. Using this new TOS system, physicians classified over 7,000 HCPCS service codes into 21 types of services. The second section of the report examines the growth in allowed charges for Medicare physician services between 1985-88 using the new TOS system.

Accession Number: PB91-188599
Price: A04

Utilization and Expenditures in a State-Sponsored Drug Benefit Program for the Elderly

This study analyzes: (1) prescription drug utilization and expenditures by elderly persons; (2) the incidence of potential drug/drug interactions in this population; and (3) sample size needed to study drug utilization in the elderly population.

Accession Number: PB91-153353
Price: A05

Utilization, Diffusion, and Substitution of High-Technology Procedures

This report analyzed the growth in utilization rates and the patterns of diffusion for three groups of high-technology physician services delivered to Medicare beneficiaries. One technology in each group represented a recent innovation, and the other represented a more established service. The services included: MRI of the head versus CAT of the head; PTCA versus CABG surgery; and extracorporeal shock wave lithotripsy versus open and endoscopic surgical techniques for eliminating stones from the kidney and upper urinary tract. Results showed that Medicare spending per eligible grew more rapidly for the newer technologies. The report also includes an exploratory investigation into modeling the diffusion of related technologies.

Accession Number: PB91-200774
Price: A09

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A06	$50.00	$55.00
A07	$56.00	$62.00
A08	$62.00	$69.00
A09	$70.00	$77.00
A10	$76.00	$84.00
A11	$82.00	$90.50
A12	$88.00	$97.00
A13	$94.00	$103.50
A14	$98.00	$108.00
A15	$98.00	$108.00
A16	$98.00	$108.00
A17	$98.00	$108.00
A18	$114.00	$125.50
A19	$114.00	$125.50
A20	$114.00	$125.50
A21	$114.00	$125.50
A22	$134.00	$147.50
A23	$134.00	$147.50
A24	$134.00	$147.50
A25	$134.00	$147.50
A99	Contact NTIS	

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E02	$34.00
E03	$38.00
E04	$45.00
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E06	$56.00
E07	$63.00
E08	$70.00
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D05	$544.00	T05	$1,290.00
D06	$644.00	T06	$1,550.00
D07	$784.00	T07	$1,790.00
D08	$884.00	T08	$2,050.00
D09	$984.00	T09	$2,290.00
D10	$1,124.00	T10	$2,530.00
D11	$1,224.00	T11	$2,770.00
D12	$1,364.00	T12	$3,030.00
D13	$1,484.00	T13	$3,270.00
D14	$1,604.00	T14	$3,530.00
D15	$1,704.00	T15	$3,790.00
D16	$1,804.00	T16	$4,030.00
D17	$1,924.00	T17	$4,250.00
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7500 Security Boulevard, N3-11-17
Baltimore, Maryland 21244-1850
(410) 786-3689

Medicaid Statistics

Information Processing Branch
Division of Health Care Information
Office of Health Care Information Services
Bureau of Data Management and Strategy
7500 Security Boulevard, N3-11-17
Baltimore, Maryland 21244-1850
(410) 786-0165

Public Use Data File Requests

Division of Health Care Information
Office of Health Care Information Services
Bureau of Data Management and Strategy
7500 Security Boulevard, N3-11-17
Baltimore, Maryland 21244-1850
(410) 786-3691

Data Release

Information Liason Branch
Division of Health Care Information
Office of Health Care Information Services
Bureau of Data Management and Strategy
7500 Security Boulevard, N3-11-17
(410) 786-3690

Mailing List Request

Name: _____

Organization: _____

Address: _____

City: _____ State: _____ ZIP Code: _____

Please select the ***one*** 2-digit code most appropriate to your situation. We are limited to four lines with 39 spaces per line. A list of audience categories and codes follows:

2-digit code

A2	Congress
B2	Federal Government
C2	State Medicaid Agencies
D2	Other State and Local Government
E2	Hospitals
F2	Hospices
G2	Health Maintenance Organizations
H2	Long-Term Care Facilities
I2	Other Health Care Providers
J2	Health Care Practitioners
K2	Health Planners
L2	Peer Review Organizations
M2	Medical Societies
N2	Beneficiary-Related Groups
O2	Libraries
P2	Universities
Q2	Independent Research Centers
R2	Foundations
S2	Medicare Part A/B Contractors
T2	Other Insurance Companies
U2	Consulting Firms
V2	Law Firms
W2	Other Private Business
X2	Trade & Professional Assoc.
Y2	HCFA Contractors & Grantees
Z2	Interested Individuals
A3	Media

Return this completed form to:

ORD, Dissemination Staff
Health Care Financing Administration
7500 Security Boulevard, C-3-11-07
Baltimore, Maryland 21244-1850

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